



The Modern Hospital

JULY 1950

*Successful nurse recruitment program • Day in the life
of a record librarian • How to handle a polio epidemic • Visual
education in the hospital • Measuring nursing service • Blue
Cross enrollment • Inhalation therapy • Group practice • Baby pictures*

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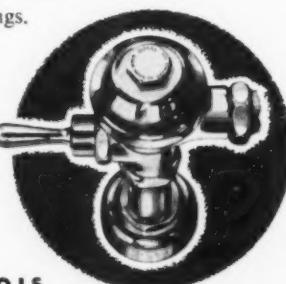
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The Modern Hospital

JULY 1950

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AMONG THE AUTHORS

Margaret K. Schafer is assistant chief of the hospital nursing section, Division of Medical and Hospital Resources, U.S. Public Health Service. A graduate of the University of Minnesota and St. Joseph's Mercy School of Nursing at Sioux City, Iowa, Miss Schafer did graduate work in public administration at the University of Michigan, where she was also an instructor in the school of nursing and served the university hospital as operating room supervisor until she joined the army nurse corps in 1942. As a lieutenant colonel, Miss Schafer was director of nurses for the European Theater of Operations and, later, personnel assistant in the Surgeon General's office in Washington. She received the Bronze Star and the Order of the British Empire in recognition of her war service. Miss Schafer's article on hospital nursing appears on page 63 of this magazine.



M. K. Schafer

Malcolm Smith is exactly what he has written about in the article on page 77 of this issue, a man who entered hospital administration via nurse's training. A native of London, England, Mr. Smith received his B.S. degree at Rutgers University in New Jersey and went to hospital nursing school in St. Louis. After two years as an industrial nurse, he joined the navy and served as pharmacist's mate on a destroyer. He was with the 8th Fleet in the Mediterranean and the invasion of France, then with the 5th Fleet at Okinawa and during the occupation of Japan. After his discharge from the navy Mr. Smith took the graduate course in hospital administration at Columbia University and has been an administrative resident at Montefiore Hospital, New York City. He became administrator of the Richmond Memorial Hospital, Staten Island, N.Y., on July 1.

Ronald A. Jydstrup is completing a year as administrative resident at the Robert Packer Hospital, Sayre, Pa., following study of hospital administration in the graduate course at the University of Minnesota. Like many other young administrators, Mr. Jydstrup dates his interest in the hospital field from his war experience; he served for three years in the medical corps of the U.S. Coast Guard, mostly in Alaska and the Aleutian Islands. As an undergraduate in the school of business administration at the University of Minnesota and during his graduate studies, Mr. Jydstrup was a member of the university's office staff in the accounting division.



R. A. Jydstrup

George H. Holmes is administrator of Ingleside Hospital for Mental Diseases, Cleveland. With the exception of the two years he spent in the navy, Mr. Holmes has been with the Ingleside Hospital since it was founded in 1935. He is a graduate of Western Reserve University and of the university's law school. The personnel methods described in his article on page 74 have the enthusiastic endorsement of Mabel A. Woodruff, founder and director of the Ingleside Hospital. "Mr. Holmes is a great exponent of teamwork," she says. "Through intensive screening and training of personnel he has expanded our facilities and services for the mentally ill."



G. H. Holmes

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Reader Opinion

Hospital Laundry

Sirs:

The article in your March issue entitled, "The Case for the Small Hospital Laundry," contains a number of statements which, in our opinion, might tend to mislead your readers. In the interest of telling the whole story, we

should like to point out some of the statements which appear questionable to us. We should be pleased to have these comments published or to expand them into an article. Here are our views on the reasons cited by the author why "it is desirable for the small hospital to operate its own laundry."

There are hospitals operating their own laundry departments under excellent management and at low costs. Several hundred of them are members of the American Institute of Laundering and their hospital laundry managers use A.I.L. services and recommendations. Even in many of these hospitals, however, the laundry department managers are not receiving the recognition that can result in lower costs and increased life to linens.

The hospital laundry manager is confronted with a number of problems. There are two basic ones. First, the laundry department is incidental to the over-all operation of a hospital. As such, it does not receive the same degree of attention accorded to the more direct activities. Successful and economical operation is largely a matter of management. And close attention to all details of operation is an integral part of good management.

Second, there are still many hospitals in which laundering is considered merely washing and ironing, without any realization of the technical aspects of modern laundering. Hospitals of this kind will not employ the type of laundry supervision necessary to obtain the best over-all results. With improper laundering methods and with improper supervision of operations the savings claimed in your article can be lost because of reduced life of the linens and in view of the very high investment for the small amount of work being handled.

The argument that the commercial laundry must use the same formula for all types of linens has no basis in fact. Commercial laundries segregate hospital work and handle it by entirely different formulas. Hospital linens are not laundered with family work. When the commercial laundry does hospital work the formula will depend upon the degree of the soil and the shorter formulas will be used when their desirability is indicated. We do not believe there is any evidence to support the assertion that linens will last longer when processed in the hospital laundry than when processed in the commercial laundry. Test piece studies by the American Institute of Laundering have produced a variety of results in this respect, both for the hospital laundries and for the commercial laundry.

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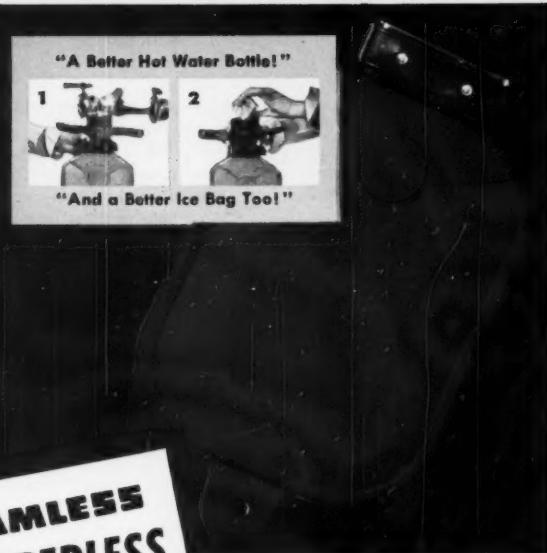
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The commercial laundry can remove stains as well as, if not better than, the small hospital laundry can.

Since the commercial laundry and the hospital laundry use the same equipment—and since the commercial laundry segregates its hospital work and uses the formula that applies to that particular kind of work—there seems to be no reason why there should be any better quality produced in a hospital laundry than could be produced in a commercial laundry. Higher quality linens will have a longer life than those of lesser quality whether washed

in the hospital laundry or the commercial laundry. All depends on training methods, technics, operating conditions, washing and finishing methods—whether the work is done in a hospital laundry or in a commercial laundry.

To our knowledge, the possibility that service may be interrupted by strikes has never been a serious problem for the small hospital. Even in the larger metropolitan cities, where union activity is greater, arrangements have been made so that laundry work done for hospitals is not interfered with during a strike. As far as war-time prob-

lems are concerned, we have only to look back to the fact that in World War II, laundries were regarded by the War Manpower Commission as being locally essential where the situation warranted.

Most contracts that hospitals have with commercial laundries are based on the type of merchandise handled. It is true that there may be one price quoted on towels and bedding and another on uniforms. This is due entirely to the cost of laundering and to no other reason. The cost of laundering any type of article will vary for the hospital laundry as it does for the commercial laundry.

Contamination and spread of disease from hospital linen are not borne out by fact. There is plenty of evidence to indicate that ordinary hospital linen—not taken from communicable wards—does not require any particular treatment to avoid the spread of disease. Even where hospitals operate their own plants, it is customary for work from communicable wards to be given special treatment prior to being sent to the laundry department. Certainly, there is no problem in the case of contagion from linens when the materials are treated prior to being sent to a commercial laundry. What applies to one type of laundry, applies to the other in this instance. An article on this subject in the December 1945 issue of the *American Journal of Public Health* by Dr. M. E. Barnes, head of the Department of Hygiene and Preventive Medicine at the State University of Iowa, is enlightening.

The health record of laundries is excellent and insurance companies regard employees as being preferred risks; they do not charge excessive premiums to laundry employees for ordinary insurance. In the serious flu epidemic following World War I, inside workers in laundries had a far better health record than did the routemen who were exposed to outdoor conditions.

Hospital laundry operating costs are of a debatable and controversial nature, since most hospital laundries do not maintain the detailed cost reports that are common in commercial laundries. There have been a number of surveys of costs of launderings in hospitals having their own laundries. According to one, the average hospital having an average patient census of 55 employs eight people to handle the laundry volume.

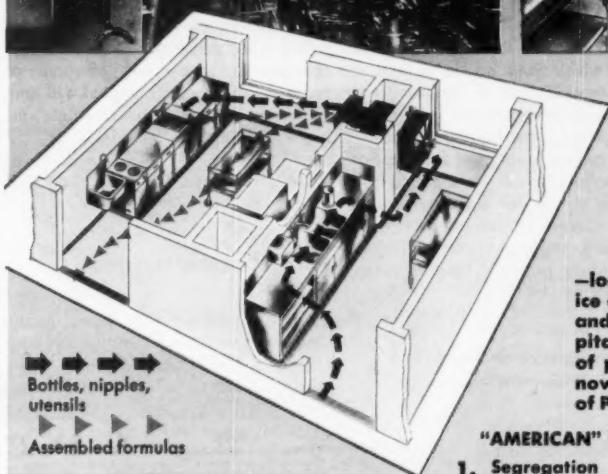
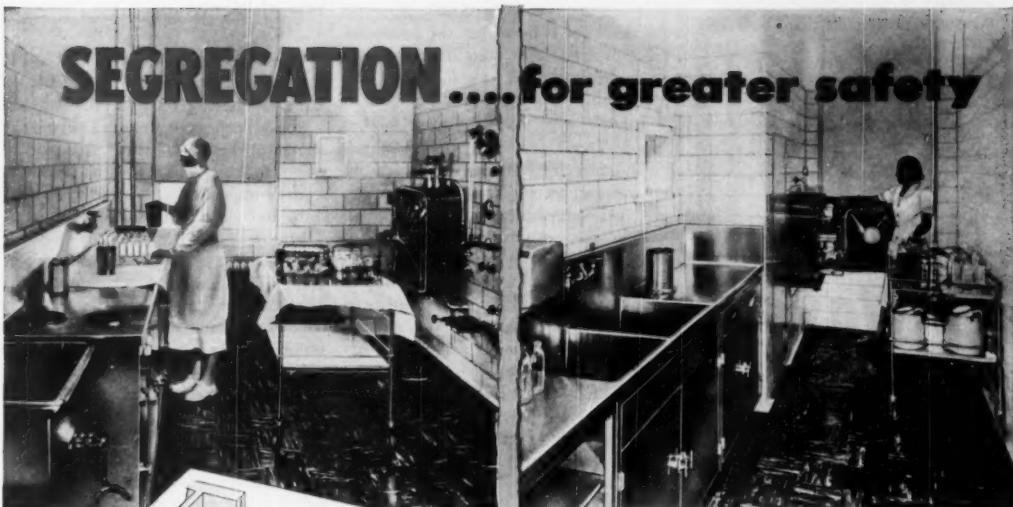
The MODERN HOSPITAL article says that one man and two girls can handle the entire volume of a typical small



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hospital at a cost of \$3.25 per 100 pounds. We believe that the following table presents labor costs that would be more nearly typical.

1 Man	@ \$1.25 per hour
7 Girls	@ 0.75 per hour
Total	\$6.50 per hour

The foregoing figures are based on an average patient census and not on the bed complement of the hospital. This is the customary method of figuring the cost of hospital laundry operations. The MODERN HOSPITAL figures show that the small hospital laundry can be expected to process 33½ pounds per hour per employee—an extremely high figure, in our opinion. Most of the studies that we have seen indicate that the production in a small hospital laundry is usually somewhere between 12 and 15 pounds per operator per hour over-all.

So much for the specific points around which your article is written. In any consideration of the laundering problems of hospitals, we believe that the following is the paramount one:

Only by providing good facilities, capable personnel and then giving that personnel the needed authority can any hospital—large or small—hope to equal the results expected from an organization whose principal business is that of laundering clothes.

A. L. Christensen
Manager

American Institute of Laundering
Dept. of Production and Engineering
Joliet, Ill.

Student Forum

Sirs:

I have read with considerable interest the letter of Alfred E. Maffly with reference to the creation of a student forum section in The MODERN HOSPITAL magazine.

This seems like an excellent idea, and I believe it would go a long way toward stimulating the thinking of those people who are just beginning to enter the field of hospital administration.

I believe that it is just as important that students learn to write on matters of hospital administration as it is to study them. Therefore, I take this opportunity to join with Mr. Maffly in urging that if it is at all possible, The MODERN HOSPITAL create such a forum.

Arthur O. Stout
Major

Medical Service Corps

Valley Forge General Hospital
Phoenixville, Pa.

War of Words

Sirs:

Under the caption "Which Half Is Private?" (April 1950) is presented a short, interesting thought-provoker!

West Virginia or Eastern Oregon, the stigma of the word "ward" accommodation (in any and all of its connotations), imposed by precedent, is anything but good advertising copy.

Might it not be well to consider taking advantage of the terms "private" and "semiprivate" accommodation? Whereas the term "ward" frequently connotes the possible existence of inferior services or accommodations, the terms "private" and "semiprivate" have been linked with excellent facilities and care. Call it glamour, class consciousness, or something psychological, we must admit it is effective.

In dealing with public opinion, which is our prime public relations representative, why not take advantage of terms which enhance our good will quotient, and alter those which might discredit our hospital facilities?

Charles F. Boyns
Pioneer Memorial Hospital
Prineville, Ore.

Hospital of the Month

Sirs:

I have received your letter stating that the Pratt County Hospital has been chosen as the Modern Hospital of the Month. It gives me great pleasure to

Cloudy



VOLUME XXXIII

Pratt County Hospital Receives First Big Honor

Has Been Designated "Modern Hospital of the Month" for May by National Hospital Magazine.

An award certificate commemorating selection of the Pratt county hospital as the "Modern Hospital of the Month" for May, 1950, will be received here soon, according to a letter received by Abbott Brown, chairman of the building committee. The hospital is due to a hospital being built under the Federal Hospital Survey and Construction Act to be completed in 1952. Hospital officials say the basis of excellence of architectural design, functional planning, economy of construction, and operation and proper functioning of the hospital are the main factors considered by the editors of the magazine's committee in a study of the architects' plans as "Hospital of the Month." The Pratt hospital is in line for the honor.

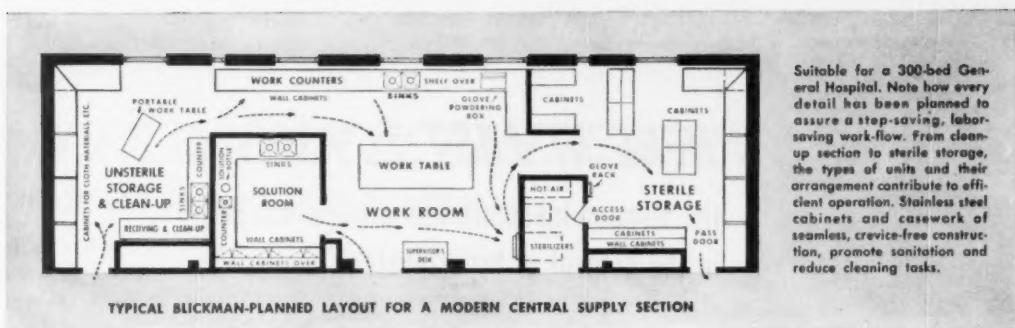
Certificates similar to the one to be received here also will be sent to the hospital architect, Thomas W. Williamson and company of Topeka, and to the division of hospital facilities, state board of health, Topeka.

Local paper reports hospital award.

know that such recognition has been given our new hospital, and praise such as this tends to make our efforts seem worth while.

Abbott Brown
Chairman
Building Committee

Pratt County Hospital
Pratt, Kan.



Suitable for a 300-bed General Hospital. Note how every detail has been planned to assure a step-saving, labor-saving work-flow. From clean-up section to sterile storage, the types of units and their arrangement contribute to efficient operation. Stainless steel cabinets and casework of seamless, crevice-free construction, promote sanitation and reduce cleaning tasks.

For Time-Saving, Step-Saving Procedures!



CENTRAL SUPPLY ROOM — St. Peter's Hospital, Albany, N.Y.
— Blickman-Built sanitary stainless steel equipment helps safeguard procedures, never needs painting, will last for years.



SOLUTION ROOM — St. Peter's Hospital, Albany, N.Y. — equipped with Blickman-Built all stainless steel units, for maximum sanitation with effortless cleaning.

Consult Blickman's Planning Service for Efficient Layout of Central Supply and Other Departments

- Let Blickman hospital consultants help you plan the best layout for your cabinets, casework, counters, sinks. Their knowledge is based upon actual experience with the problems of many leading institutions. The layout they recommend will be based on your own hospital procedures, and will indicate the best and most efficient work-flow as shown by your specific operations.

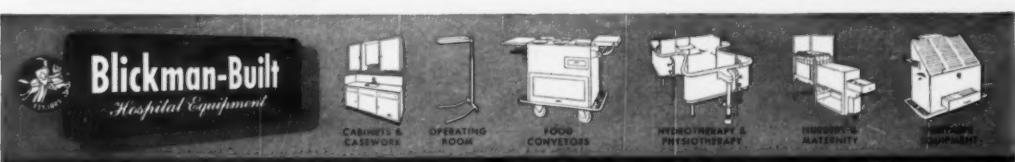
To make sure that you get the efficiency planned for, Blickman follows through with the design and construction of individual units, and final installation. With this 3-fold service — planning, fabrication, installation — you are assured of equipment that will endure for years. Blickman's famous all-welded stainless steel construction, in fact, can be expected to last for the life of the building. Both *permanence* and hospital-standard *cleanliness* are built into these units. The smooth, crevice-free surfaces are easy to clean, remain permanently bright. Rounded corners in sinks and similar units are other important aids to sanitation. Maintenance and replacement costs are practically eliminated.

If you are considering new construction, renovations or additional equipment for Central Supply — or any other department — it will pay you to consult with Blickman first!



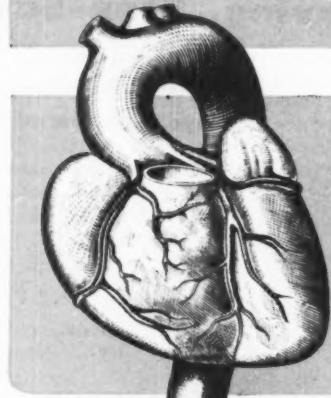
Send for Bulletin 10-CBC — illustrating and describing Blickman-Built cabinets and casework . . . The services of our consulting staff are at your disposal, to help plan Central Supply and Utility Rooms, Milk Formula Rooms, Laboratories, Diet Kitchens and other departments of your hospital.

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New England Branch: 10 High Street, Boston 10, Mass.



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the weapon medicine has always wanted
in the control of hypertension



VERILOID*

Product of Riker Research

A potent alkaloidal extract of *Veratrum viride*—biologically standardized for hypotensive activity in mammals—a new active principle not heretofore available, for the treatment of all forms of hypertension

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IN EVERY FORM OF HYPERTENSION

a new and more efficacious approach

Pharmacologic research covering three years, embracing more than 2000 individual animal experiments in mammals, and clinical studies including uninterrupted administration to a large group of patients for a full year have established the therapeutic efficacy of Veriloid.* Thus the achievement of isolating the active ester alkaloids of *Veratrum viride* has resulted in a distinct contribution to the management of hypertension.

- **AN ENTIRELY NEW DRUG.** Veriloid makes available for the first time the hypotensive ester alkaloids of *Veratrum viride* obtained by an exclusive extraction process which separates these active principles from inert material and less desirable alkaloids. The finished product represents, on a weight basis, less than one-tenth of one per cent of the crude drug from which it is derived.
- **A DEPENDABLE HYPOTENSIVE PRINCIPLE.** The hypotensive activity of Veriloid is predictable and dependable. The drug exerts a selective relaxing action on the smaller blood vessels, leading to their dilatation, hence to a drop in blood pressure.
- **UNIFORM POTENCY.** Biologic standardization of the purified extract in dogs, *using depression of the blood pressure as the end point*, insures absolute constancy of pharmacologic activity.
- **PROMPT, SUSTAINED CLINICAL EFFECT.** While individualization of dosage is essential for maximum therapeutic benefit, in the majority of patients the average dose of Veriloid—2.0 mg. to 5.0 mg. three or four times daily after meals and at bedtime—produces a sustained lowering of the arterial tension. The degree of drop usually results in marked subjective improvement. Veriloid is indicated in all forms of hypertension.

Veriloid is available on prescription through all pharmacies in slow dissolving tablets containing 1.0 mg., in bottles of 100 and 200.

*REFERENCES

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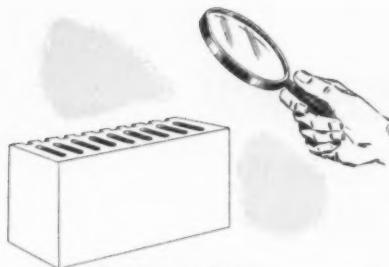
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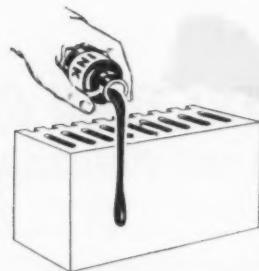
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inspection



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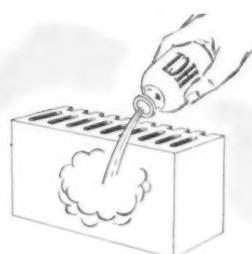
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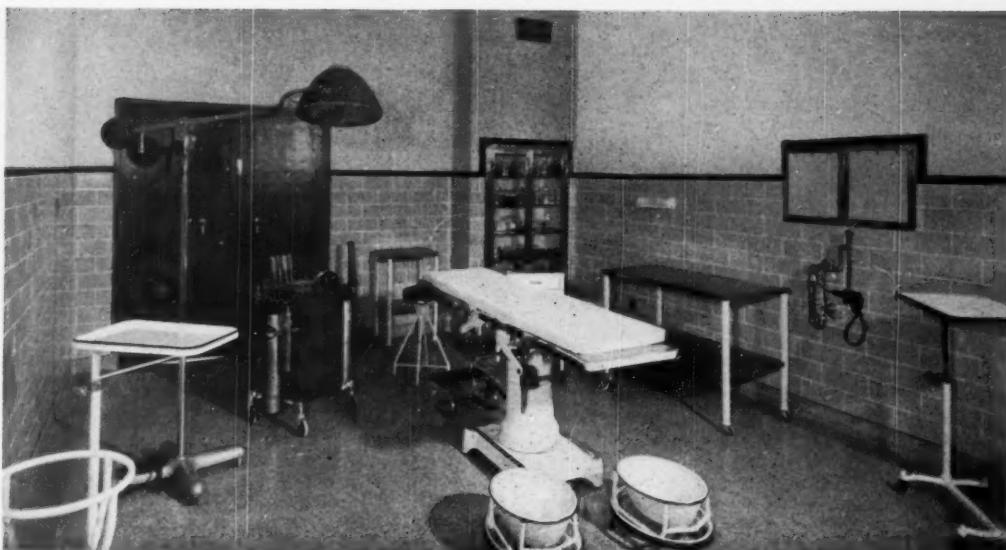
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Like almost all manufacturers we occasionally like to talk about the quality of our product—Structural Clay Facing Tile. But, when we do, we want it to *mean something*, tangible and specific, to you.

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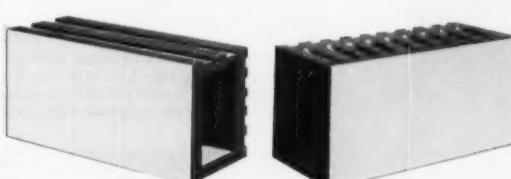
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PRODUCTS FOR EVERY SOUND CONDITIONING PURPOSE

The MODERN HOSPITAL



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COLOR FUSED TO UNDERSIDE
PLASTIC COVERING MATERIAL

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Color fused to
underside of
transparent vinyl
sheet . . . backed
by flocking

ELGIN "Double-Check" WATER SOFTENER

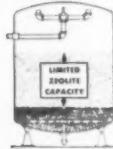


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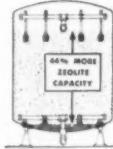
Double-Check principle gives you up to 44% more soft water

Yes, the "Double-Check" design gives you up to 44% more soft water from the same size softener using the same type of zeolite — proved in thousands of installations.

It does this because the "Double-Check" manifold system prevents the escape of zeolite and thus permits using a larger amount of zeolite in a given-size tank. More zeolite means more water softening of course. Preventing its escape also permits faster, more thorough back-washing; assures more effective regeneration; reduced salt consumption; higher efficiency; maximum economy. The two diagrams below tell the story of this revolutionary development.



ORDINARY DESIGN
Some Size Units . . . Same Type Zeolite



ELGIN DESIGN
Same Size Units . . . Same Type Zeolite

2 QUALITY

Better construction means more years of low cost operation

When you examine the present-day Elgin you find that we have put not only advanced design into it, but also higher quality and finer workmanship.

There is none of the assembled, thrown-together construction that is too prevalent today; no skimping of materials. Instead you find well designed, Elgin-built components that assure longer life and trouble-free operation. Contrast the precision-built Elgin Multiport Valve, "Double-Check" Manifold, Backwash Regulator, with the construction found in other softeners and you will know how much more real value you get in the Elgin.

Thanks to elaborate tooling and modern streamlined production methods you pay no more for the higher quality of the Elgin "Double-Check" Softener.

Write today for facts about the softener that is ahead on all counts

3 SERVICE

Elgin servicing maintains top efficiency

Complete, capable service has always been an important plus factor with Elgin. Our interest never ends with the sale. Through the years it has always been our established policy to keep every Elgin installation operating at peak efficiency and to aid the operator in obtaining greatest benefits from its use. Elgin's service program, now better than ever, has been placed on an organized, concrete schedule which assures your realizing the outstanding performance which every Elgin product is designed to give.

"DOUBLE-CHECK" CAN BE APPLIED TO YOUR PRESENT SOFTENER

Existing softeners of any make can be modernized to incorporate the features and advantages of the Elgin "Double-Check" principle. Many modernization jobs equipped with "Double-Check" and Elgin high capacity zeolites have stepped up capacity 3 to 10 times.



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- Corrosion prevention in hot and cold water piping
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- Aerators and degassifiers
- Chemical feeders
- Water testing apparatus
- Zeolites of all types

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New 150 P.KV.
Mobile
Therapy
Unit**

*for Greater
FLEXIBILITY
and **MOBILITY***

For maximum f-l-e-x-i-b-i-l-i-t-y in intermediate and superficial x-ray therapy—and the advantage of being easily and quickly moved about, Standard's New Model 150 P.K.V.

Unit is winning acclaim. This newly designed and Standard-built apparatus is readily adjusted for any desired positioning of the beam to the patient. The unit's narrow width and large casters assure easy movement through doors and in and out of elevators. As a matter of fact only 18 lbs. pressure will start it and 15 lbs. will keep it rolling!

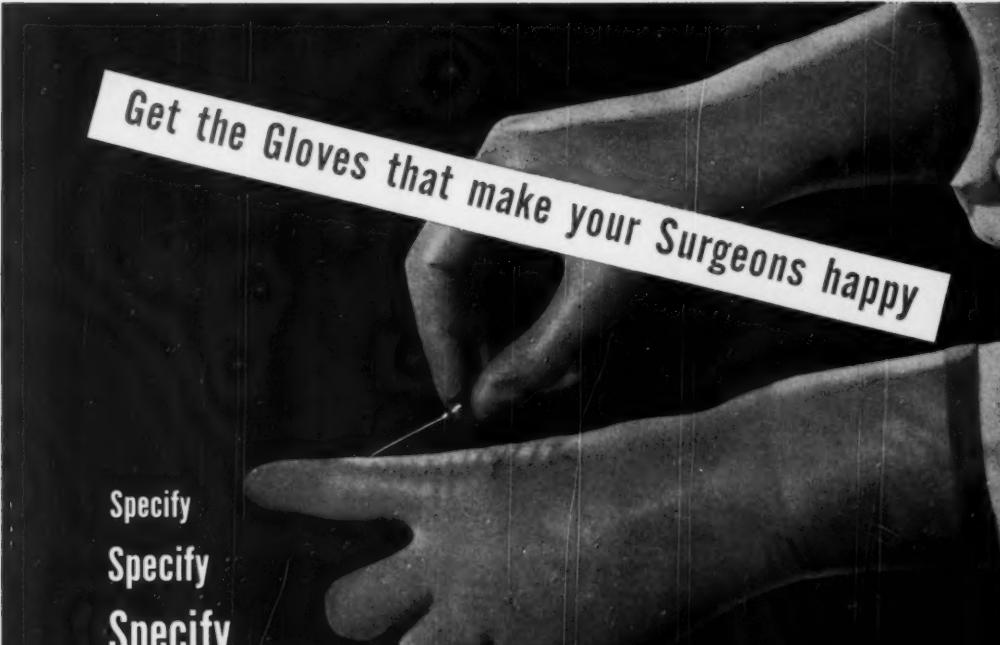
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THE

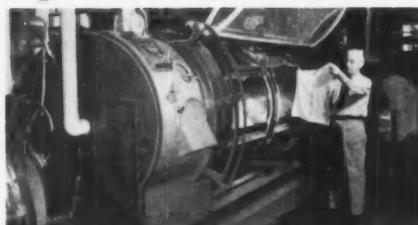
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THE SAME-SIZE LAUNDRY
now can do **31%** MORE LINEN

City Hospital of Akron Gains Important Laundry Economies by Modernizing with **HOFFMAN** Equipment



Unique washing principle of the Hoffman "Shell-less" washers processes loads faster—saves space, water, steam and supplies.



The Hoffman 50-inch unloading extractor saves time and cost of handling wet and extracted loads.

Better laundry operation need not mean junking all existing equipment, and sizable new investment. Take the case of the private, non-profit City Hospital of Akron.

A few years back, it decided that laundry efficiency could be improved with larger washers. Studies made by a Hoffman Laundry Engineer suggested the installation of two "Shell-less" washers (for increased capacity and future needs) and of a 50-inch unloading extractor to match their output. Also, recommendation was made that two 36 x 30 "Ucon" tumblers be added for economy in handling small lots. Except for a revised floor arrangement, balance of the equipment was machines already in use.

Without any increase in physical size, capacity of the laundry has been increased 31%. Operation of "Shell-less" washers has meant big savings in water, fuel, supplies and linen. With the unloading extractor, washing and handling time and labor have been substantially reduced.

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COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION CORPORATION
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MENGEL means *QUALITY* in Hollow-Core **FLUSH DOORS**

- 1 Balanced seven-ply construction to provide controlled reaction in changing weather conditions.
- 2 Hardwood construction throughout—stronger, more durable, free from grain-raising, more easily and economically finished.
- 3 Exclusive Insulok grid core material has inherent resiliency, cannot cause warping, nor transfer grid pattern to faces.
- 4 Greater strength. Adequate core stock surface area provides maximum gluing surface and resistance to warpage.
- 5 Precision key-locked dove-tail joinings of stiles and rails add strength and stability.
- 6 Ready to finish. Door faces are smoothly belt-sanded. Stiles are machine-planed at factory—prefit to standard book sizes.
- 7 Fully guaranteed. Each door must meet rigid quality control standards and constant inspection throughout manufacture.
- 8 Mengel Flush Doors are economical—no mouldings to paint—no corners to collect dirt. Smooth hardwood surfaces are less absorbent and less costly to finish—easier to clean and longer-lived.

Write for complete specifications. Use the coupon.

Also see—

MENGEL STABILIZED SOLID-CORE DOORS
the finest products of their type on the market.

The Mengel Co., Plywood Division
2318 South Fourth Street, Louisville, Ky.
Gentlemen: Please send me, without obligation,
full specifications on Mengel Hollow-Core Flush
Doors; Mengel Stabilized Solid-Core Doors.

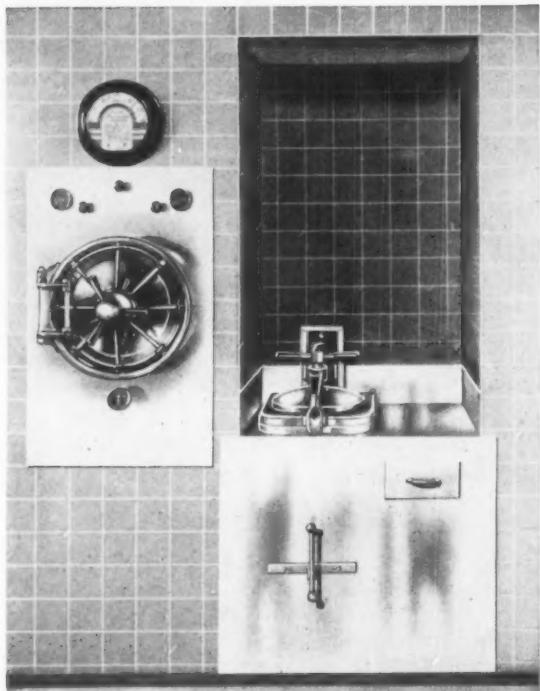
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THE PATIENT COMES FIRST

In Any Recommendation We Make



Left: Hi-Speed Emergency Instrument Sterilizer.
Right: Instrument Washer-Sterilizer. Both Recessed.

Sometimes because of budget limitations one piece of equipment must do the work of two. In this situation, the Washer-Sterilizer can be used in an emergency as a simple, high-speed pressure instrument sterilizer. It is designed to do this job quickly and well.

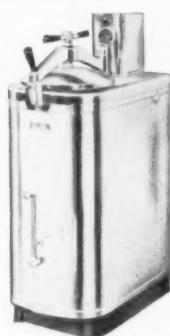
For full details see your Castle dealer or write: Wilmot Castle Co., 1175 University Ave., Rochester 7, N. Y.

The Castle Instrument Washer-Sterilizer with the Hi-Speed Sterilizer make an ideal team. Each eliminates a specific threat to patient safety:

1 The Washer-Sterilizer washes and gives ideal sterilization of all operating instruments. It enforces rigid, inflexible aseptic technique and saves drudgery and mess in the operating suite. It is a highly efficient routine sterilizing tool which is in nearly constant use.

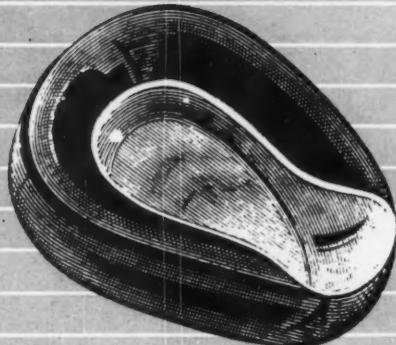
2 The Castle Hi-Speed Sterilizer processes instruments dropped, or suddenly required through change in trend of surgery, or an instrument overlooked when kit was originally prepared. The Hi-Speed is extremely fast. It is primarily a stand-by and should be ready for instant use whenever an operation is in progress.

The combination of these two Castle sterilizers to meet two separate problems is the ideal for patient safety.



Instrument Washer-Sterilizer,
Cabinet Model

Castle LIGHTS AND STERILIZERS



the Bedpan

...for generations the most unwelcomed, unwanted, uncivilized piece of equipment in the hospital...

IS NO LONGER NECESSARY

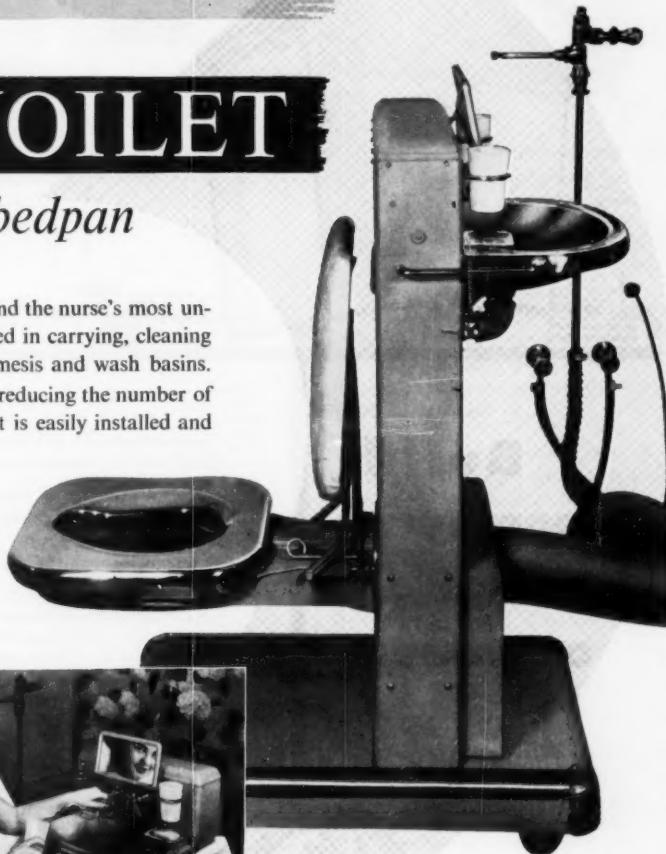
the LAVOILET

eliminates the bedpan

It ends patient embarrassment and the nurse's most unwanted task. It saves time expended in carrying, cleaning and sterilizing bedpans, urinals, emesis and wash basins.

It saves money and space by reducing the number of bathrooms required for patients. It is easily installed and convenient to use.

Now is the time to make the LAVOILET a part of anticipated planning—whether it be building, expanding, or modernizing. May we send you more details?



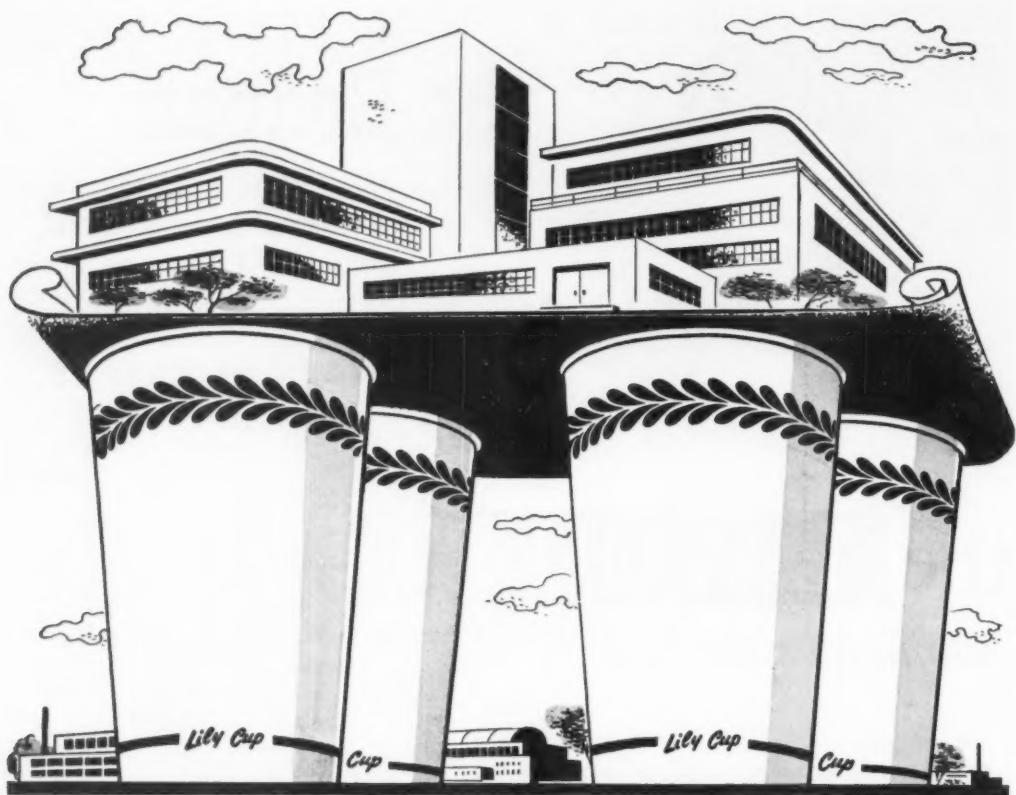
At right — full length view of Lavoilet which provides flushing toilet and lavatory with hot and cold running water.

Patient may use toilet or lavatory, in or out of bed. Toilet is automatically (electrically) adjusted to bed height.



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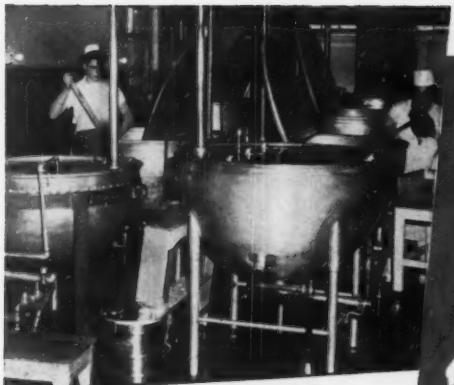
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Norfolk State Hospital, Norfolk, Neb.
(Regular kitchen chefs shown in photo)

TALK ABOUT Minimum
REPLACEMENT COSTS...THESE
WEAR-EVER KETTLES ARE
25 YEARS OLD
and still going strong

DR. G. E. CHARLTON
SUPERINTENDENT



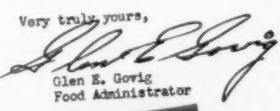
State of Nebraska
NORFOLK STATE HOSPITAL
NORFOLK

April 20
1950

The Aluminum Cooking Utensil Company
100 Dierks Building
Kansas City 6
Missouri

Gentlemen:

For the past twenty years or more, Wear-Ever Aluminum Steam Jacketed Kettles have been used exclusively in the kitchen cooking qualities have served us in many ways — from making soup to roasting beef, pork, and even fowl. Some of our kettles are still in daily use after twenty-five years service. In our kitchen, which uses a great deal of inmate help, Wear-Ever heavy duty aluminum utensils have given us many years of outstanding service. We here at Norfolk very much appreciate Wear-Ever Aluminum.

Very truly yours,

Glen E. Gowig
Food Administrator

These kettles haven't been "babied" either. Notice what Norfolk State Hospital says about using a great deal of inmate help.

Today, Wear-Ever Aluminum Steam Jacketed Kettles are made of a recently developed alloy that is much harder than any previously used. This extra-hard alloy is further assurance that Wear-Ever Aluminum Kettles are built to LAST.

Approved sanitary construction, unbeatable cooking qualities, tangent draw off, space-saving design, new features . . . ask your dealer for information about these and other outstanding Wear-Ever advantages. Or write: The Aluminum Cooking Utensil Company, 707 Wear-Ever Building, New Kensington, Pa.

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Please send me complete descriptive information regarding your new line of steam jacketed kettles in extra hard alloy.

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FOR WOOD, ASPHALT, RUBBER TILE,
CEMENT AND LINOLEUM FLOORS

WYANDOTTE Floor Wax is a no-rubbing, emulsion-type wax. It is water-repellent, listed by the Underwriters' Laboratories as "anti-slip." It contains a minimum of 12.5% solids. When Wyandotte Wax is applied, the water and volatile emulsifier are evaporated, leaving a hard, dry wax surface with a satin sheen. This surface is not slippery . . . not tacky. It may be polished to a high gloss. Two coats on a clean floor are usually sufficient. Each additional coat gives greater beauty, longer wear, and increases slip resistance. Ask your Wyandotte Representative or Supplier to demonstrate the "finger-skid" test.

- Anti-slip
- Washable
- Strips easily
- Resists dirt and wear
- No rubbing
- Easy to maintain
- Carnauba wax base
- Contains no shellac or resins
- 100% vegetable wax

THE WYANDOTTE LINE—floor and wall cleaners: Detergent, F-100; marble cleaner and poultice: Detergent; tile and porcelain cleaners: Detergent, F-100, Paydet; cement cleaner: El-Bee; floor wax: Anti-Slip Wax; germicides and sanitizers: Steri-Chlor, Spartec—in fact, specialized products for every cleaning need.



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Papers for patients make talk for South Dakota hospital!

Every morning patients in a noted South Dakota hospital receive copies of the local morning newspaper with their breakfasts. This little extra touch is deeply appreciated by the patients, has won the hospital a great deal of praise.

DOUBLE DISHES BRING SUPER SERVICE!

A well-known Illinois hospital has speeded up its mealtime service tremendously by using two distinctive dish patterns. One type is used for tray service, the other for the employees' dining room. Efficiency is increased because smaller-sized dishes are needed for patients' trays, and these dishes are easily distinguished from the dining-room dishes by the pattern. Patterns were picked so that both types could be easily used together in an emergency.

PEOPLE WHO TALK ABOUT GOOD FOOD... TALK ABOUT

**People talk for you
when you use
"SIGNS" that inspire confidence**



People have confidence when they see this AAA sign.
Experience tells them it means high standards of quality.

In your restaurant or hospital, you can use similar
"signs" to convince folks you serve outstanding
food. These "signs" are famous brand names you list
on your menus or display on your tables.

Nationally-known brands convince people you serve
outstanding food, because they use these same
brands in their own homes.

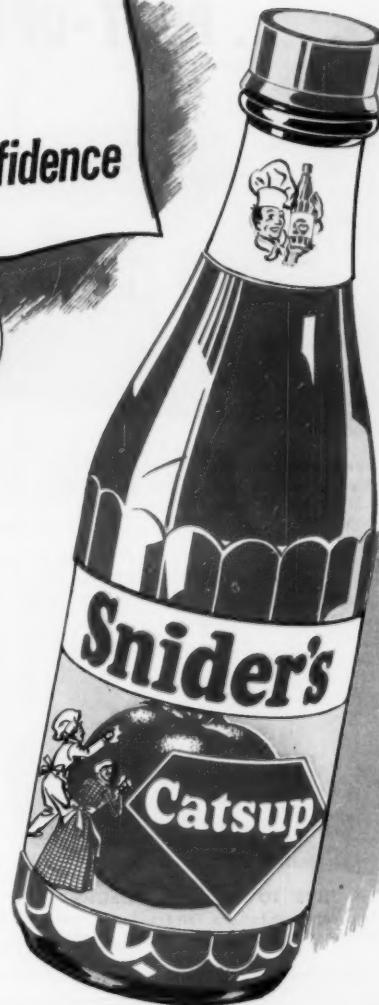
Such famous brands are Snider's Condiments,
Log Cabin Syrup, Post's Cereals, the special
institution blend of Maxwell House Coffee; and all
the other General Foods Institution Products. Let these
products show people the fine quality of *your* food.

**Get Premium Quality at
No Extra Cost with SNIDER'S!**

Snider's Condiments are used regularly
in millions of homes. Putting them
on your tables immediately stamps you
as a server of quality foods. Yet
Snider's cost you little, if any, more
than ordinary brands. And Snider's,
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.... POST-OPERATIVE SAFETY

is increased by using the
new Hausted Wheel Stretcher



MOVES PATIENT OVER THE BED --

With a simple turn of the crank the stretcher moves over the bed.



THEN TILTS TO TRANSFER POSITION

Just continue to turn the crank and the stretcher top tilts to the proper angle.



TRANSFERS PATIENT WITHOUT EFFORT

When the stretcher top is tilted one nurse can quickly and easily transfer the patient from stretcher to bed.



The Hausted "Easy Lift" Stretcher has been designed to provide maximum safety for patients, even after the most delicate of operations. The patient remains absolutely inert during the entire transfer from stretcher to bed. There is no need to disturb the patient by lifting as is necessary with old style equipment.

Every feature of the Hausted unit has been designed with the patient's safety in mind. For instance, as the top tilts it recesses into the mattress of the bed. This provides a "locking action" that prevents all movement of the stretcher during the patient transfer.

The "Easy Lift" Stretcher combines the features of several old type units. No longer need hospitals buy several pieces of equipment to transfer patients.

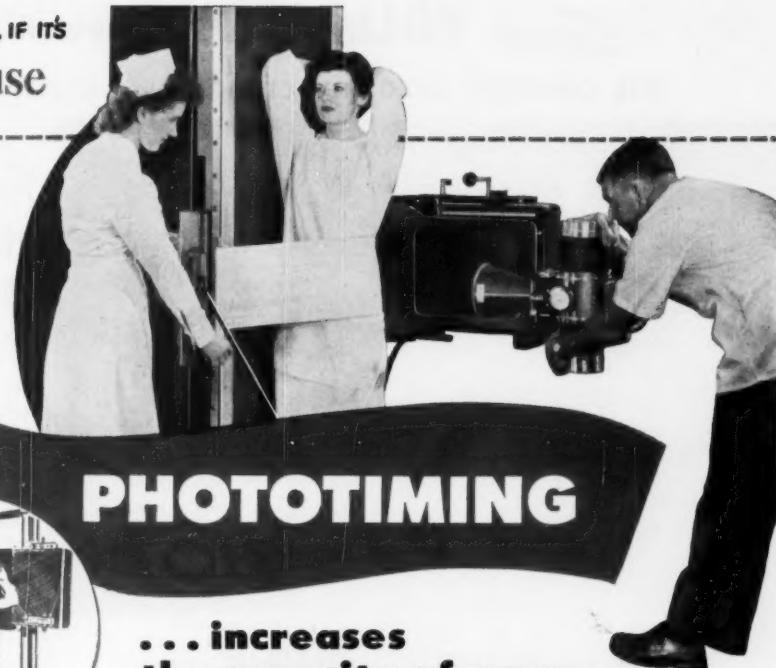
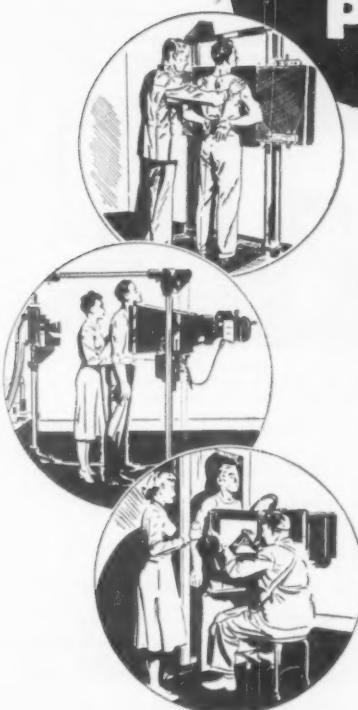


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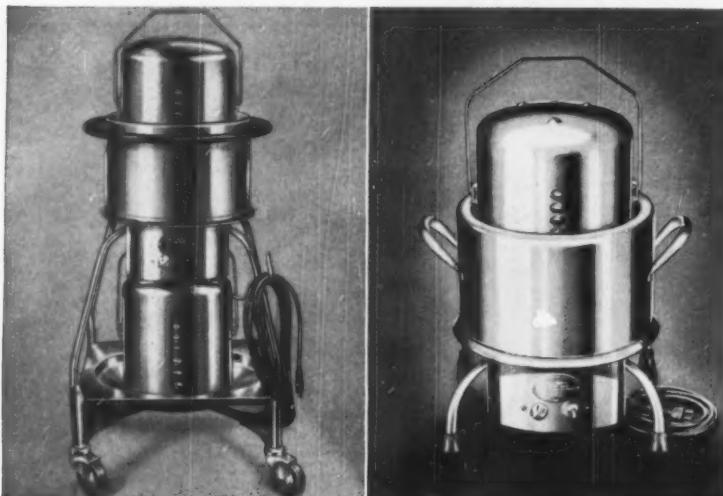
Call your local Westinghouse X-Ray Representative to learn how phototimers may be added to your present equipment or included when you purchase new apparatus. Or, if you wish, write to Westinghouse Electric Corporation, 2519 Wilkens Ave., Baltimore 3, Maryland.

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Stainless Steel
**POLIO-PAK
HEATERS**

Easy and simple to operate. Equipped with cut-off switch that prevents damage to heaters if inadvertently allowed to boil dry. Ideal for any hot-pack therapy, including hot-pack treatment for poliomyelitis. Circulars on request.



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BED PAN
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THE MATERIAL: Surface-chromicized after spinning and drying. The chrome concentration is very high in the surface layers and relatively low in the core of the strand.

THE RESULT: In enzyme solution, the core of most surface-chromicized catgut digests readily, leaving a hollow cylinder which separates into ribbons.

This cylinder may be excessively resistant to enzyme action and persist in tissue, frequently leading to knot extrusion.

Surface-Chromicized Catgut

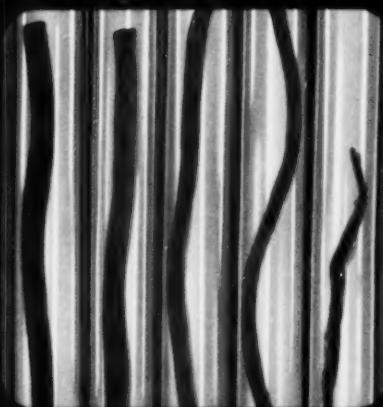


Enlarged photograph of five stages of digestion of surface-chromicized gut in trypsin solution.

THE MATERIAL: By the Tru-Chromicizing method, individual ribbons of catgut are soaked in chrome bath *before* they are spun into strand, permitting uniform deposition and full control of chrome concentration.

THE RESULT: The Tru-Chromicized strand has the same chrome content from periphery to center, and hence exhibits uniform enzyme resistance throughout digestion. Ethicon's Tru-Chromicized gut digests on the surface and retains its integrity as a unified suture until digestion approaches completion. Total digestion eliminates knot extrusions.

Ethicon Tru-Chromicized Catgut



Enlarged photograph of five stages of digestion of Tru-Chromicized gut in trypsin solution.

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Sutures

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Use these new aids to improved surgical technic

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ALL SURGEONS

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Here are two of Ethicon's contributions to safer, simpler surgery—Bio-Sorb Powder and the Seamless Atraloc Needle.

Bio-Sorb Powder displaces the always potentially dangerous talc.

Seamless Atraloc Needles, with the smooth shank, possess uniform high temper, without soft areas. Parallel flattened surfaces permit firm grasp by needle holder. All points are hand-honed.

If you are not familiar with the many advantages of Bio-Sorb and Atraloc, your local representative can supply full information.

Order from your Surgical Dealer



Color photograph of a group of adhesions showing the agglutinated talc masses appearing as white flecks within the adhesions.

Color photograph of small bowel of a dog treated with Bio-Sorb Powder. Note complete absence of adhesions or demonstrable inflammatory reaction.

Glove Powder Adhesions Eliminated With New Bio-Sorb Starch Powder.

Postoperative adhesions caused by glove powder have long been a serious concern of surgeons and operating room assistants. All published studies agree that talc as a glove lubricant is unsafe.

As a replacement for talc, a wholly safe and efficient dusting powder is now available. This new powder, called Bio-Sorb, is a mixture of amylose and amylopectin, derived from corn starch, which has been treated by special physical and chemical means to prevent gelatinization when the product is autoclaved. It is treated physically and chemically to assure good lubrication after sterilization.

Talc consists chiefly of magnesium silicate. It causes granulomatous reactions in tissue, resulting in intra-abdominal adhesions, persistent sinus formation, or nodules in the wound.

Implantation of glove powder may occur from unwashed gloves, perforations in gloves, spill on to sponges, instruments and suture material, and by the air-borne route.

Bio-Sorb is compatible with body tissues and is rapidly absorbed. It does not injure rubber gloves. It fits regular O. R. techniques. Costs less than 2 cents per operation. Bio-Sorb has been used over three years in several hundred hospitals. Complete literature mailed on request.

BIO-SORB POWDER
BRAND OF STARCH DERIVATIVE DUSTING POWDER



FOR ABDOMINAL CLOSURE

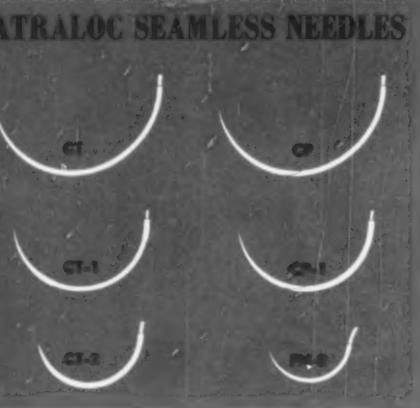
Six New Needles Serve Most All Purposes

For Ob., Gyn. and general closure, sutures swaged to eyeless needles are increasing in preference among surgeons.

The Atraloc seamless needle draws a single strand of suture through the tissues, eliminating confusion and minimizing trauma.

After extensive research in surgeon's preferences, Ethicon designed the 6 needles shown at left, which meet the requirements for 80% of the needles used in abdominal closure.

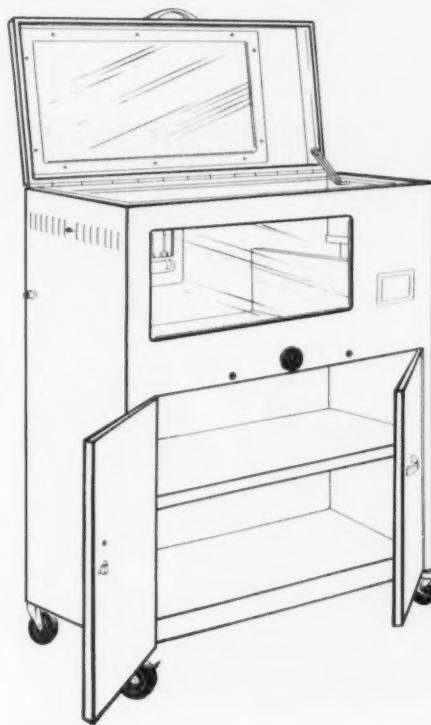
These needles are swaged to Ethicon's Tru-Gauged, Tru-Chromicized Surgical Gut, noted for its strength and flexibility.



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Suture Laboratories at New Brunswick, N. J.; Chicago, Ill.; Sao Paulo, Brazil;
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The LIVSEY INFANT
INCUBATOR is low
in original cost; low
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TO PROTECT DELICATE LIVES

The LIVSEY INFANT INCUBATOR is especially designed for *one* purpose: to protect the infant's life. It is precision made of the finest materials; constructed for administration of aerosol therapy and oxygen, as well as other advantages, conveniences and protective safeguards.

Only LIVSEY uses RADIANT HEATING, which offers the most steady, even, continuous warmth available in an incubator. Heat waves are radiated from the entire bottom and back surfaces of the infant compartment. There are no over-heated or cold areas. The temperature is easily adjusted by means of a single control. An infant's life depends upon the complete reliability of the incubator, its ability to offer a precision balanced performance. The difference saves lives.

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Tested and approved for safety and reliability by Underwriters' Laboratories and Canadian Standards Association. Write to the LIVSEY Equipment Company, Dept. 11, Box 830 Warrensville Station, Cleveland 22, Ohio, for a free descriptive brochure.

L I V S E Y



Frederic Fenger 1877-

Frederic Fenger, a pioneer in the field of Endocrinology, has completed 43 years of continuous investigation in this field while associated with The Armour Laboratories.

Frederic Fenger, a nephew of the renowned surgeon and lecturer, Christian Fenger, was born in Copenhagen, Denmark, November 12, 1877. He graduated from the University of Copenhagen in 1901 and came to the United States in 1904. In 1906 he joined The Armour Laboratories, and developed the research laboratory of organo-therapeutics. During his active laboratory research, Fenger published 36 articles. His early work on enzymes assisted greatly in a clearer understanding of enzymosis as related to body function, as well as the application of enzymatic action when applied to many chemical processes. In 1927, Frederic Fenger produced a 70,000 Pepsin by isoelectric precipitation — this is the purest known form of this digestive enzyme.

The study of the thyroid gland also was an all important contribution by the scientist Fenger. His collaboration, in 1913, with Seidell of the United States Public Health on the study of the seasonal variation of the iodine content in livestock animals introduced the need for accurate standardization procedures in the manufacturing and processing of thyroid for medicinal purposes.

Fenger assisted in the standardization of Posterior Pituitary preparations and prepared the first standard, which was adopted later and still remains the standard for determining the oxytocic activity of the posterior pituitary gland.

Fenger's assistance to the many early investigators in the field of Endocrinology was worldwide. Many scientists received their early guidance from Fenger's inspirations and relied on his ability and innate creative ability to supply them with the initial starting material for many pioneer investigations in endocrinology.

Sixteenth in the series,
PORTRAITS OF PIONEERS
in Endocrinology. A full-
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painting, suitable for fram-
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When is metabolic combustion low?

Metabolic combustion is at a very low level in myxedema and cretinism. In lesser, subclinical or partial deficiencies physiologic oxidation is more rapid but still below normal. For both minor and major thyroid deficiencies, the quality of the thyroid medication is of utmost importance.

Thyroid Armour

is made from the world's largest supply of fresh raw material. Armour selects and blends the animal glands in order to compensate for their regional and seasonal variation in iodine content. Armour was also first to institute methods of assaying and blending the glands to fixed standards.

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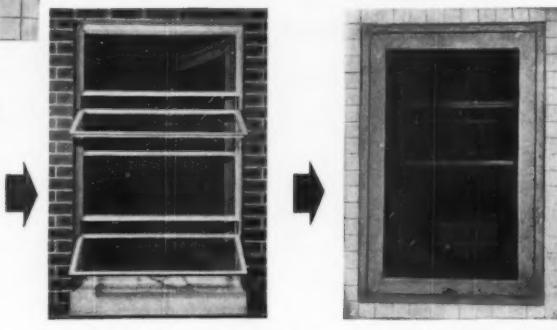
**PROTECT
your mental patients
with the first complete**

The FENESTRA Package

- Strong, good-looking window
- Adjuster and bronze handle
- Metal casing
- Choice of Safety, Protection or Fly Screen

The FENESTRA protection

- Window vents, small, with openings limited, to bar escape
- Flush installation inside to eliminate ledges—no climbing
- No locks or bars to suggest restraint or detention
- Removable adjuster handle—easily concealed by attendant
- Safety Screen with concealed shock absorbers



Fenestra* Psychiatric Package Windows provide abundant daylight, controlled ventilation, easy operation. They're weather-tight—double contact all around ventilators. They're cleaned and screened easily from inside the room. Their Bonderizing and baked-on prime paint protect against rust. Made of steel, they are fire-safe.

The Fenestra Safety Screen is made of stainless steel and double crimped mesh of tremendous tensile strength. Protection Screen has same features except for shock absorbers. Both keep

out insects as effectively as does the Fly Screen.

For real protection for your patients—at remarkably low cost—select this new Fenestra Psychiatric Package Window. Call your Fenestra Sales-Engineer, representative of America's oldest and largest steel window manufacturer, for full information. See the yellow pages of your telephone directory.

Or write to Detroit Steel Products Company,
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Double the Capacity
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Laundry Tumbler, only
\$770.00 f.o.b. Mil-
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Inventor and World's
Largest Maker of
Open-End Drying Tum-
blers.



Another Top Producer **HUEBSCH** gas-heated TUMBLER

Ideal for small laundry installations or as an additional unit for extra capacity. Three sizes: 36" x 30", 36" x 24", 36" x 18". Low gas consumption. Fast drying. Trouble-free operation. Has all HUEBSCH design and construction advantages. Low cost.

**Large Volume Drying
at Lower Cost**

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HUEBSCH "42" Open-End Tumbler

1. FASTER DRYING. The HUEBSCH "42" will substantially outrun larger and more expensive cylinder-door type tumblers.

2. SAVES FUEL AND POWER. Requires less steam and less motor horsepower to operate. Only 1 H.P. motor is used.

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4. LOWER MAINTENANCE. Famous HUEBSCH construction assures lasting durability, and years of trouble-free operation.

If you want faster, more efficient drying than you have ever had before, the HUEBSCH "42" is the *buy* for you. All of the money-saving advantages above have been proved in actual use. Although the "42" has a large capacity of 100 lbs., it occupies less space than you would normally expect. Flexibility in operation is another important asset. A battery of HUEBSCH Tumblers, each operating independently, assures you of continuous operation in the event one is temporarily out of commission.

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Originators

Open-End Tumbler Handkerchief Ironer and Fluffer Pants
Shaper Automatic Valves Feather Renovator Double
Sleever Collar Shaper and Ironer Garment Bagger
Cabinet and Garment Dryers Washometer Hosiery Ironers

HUEBSCH MANUFACTURING COMPANY, 3775 N. Halsted St., Milwaukee 1, Wisc.

"Our Baking and Roasting Ovens
Prove that

**GAS is the most Versatile
and Economical Fuel
for VOLUME COOKING"**

A. Lucille Brooks,
Supervising Dietitian



Homer Folks Tuberculosis Hospital
Oneonta, New York.



Unloading bread from two-section
Martin Variety Oven.



Partial view of kitchen showing some of the modern Gas Equipment
and illustrating the compactness of the Gas-Fired Variety Ovens.

MULTI-PURPOSE PERFORMANCE is a pretty important factor in the selection of kitchen equipment for volume food preparation—the kind of flexibility you find in the modern Gas Ovens at Homer Folks Tuberculosis Hospital, Oneonta, New York.

These sectional Gas Ovens, with separate automatic temperature controls for each chamber, are used for a wide variety of baked goods as well as for heavy-duty roasting. As Miss Lucille Brooks, Supervising Dietitian, expresses it—

"Although we often require the total capacity, there are many times when we need only one or two chambers and then our Gas Ovens provide just the temperatures required, quickly and with a remarkable saving in GAS cost."

Like all modern Gas Cooking Tools, these sectional ovens are efficient, clean, and economical—with the versatility of performance which facilitates cost-control in volume food preparation and service.

With modern Gas Equipment you need not sacrifice any of the essentials of good cooking, or efficient kitchen operation, because GAS offers every advantage in economy, cleanliness, speed and flexibility.

Today is a good day to call your Gas Company Representative for a check-up on modern Gas Equipment.

Illustrations and information furnished by Martin Oven Company, Inc.,
Rochester, New York, manufacturers of Gas-fired Variety Ovens.

AMERICAN GAS ASSOCIATION

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SERVE DELICIOUS HOT MEALS EVEN HOURS AFTER PREPARATION!

MINIMIZE FOOD SERVICE FLOOR SPACE!

REDUCE FLOOR PANTRY EQUIPMENT and PERSONNEL!

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• The Mealpack System permits the serving of delicious, piping hot meals at any time—even two or three hours after cooking and packing. It minimizes floor space . . . reduces extra equipment and personnel required for floor pantries. It combines the advantages of both the centralized and decentralized serving systems.

In short, MEALPACK provides a convenient, time-saving and labor-saving method of serving more appetizing, nutritious food—at lower cost.



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MEALPACK CORPORATION

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above: The TRAY CART is a "portable floor pantry." Loaded with individualized, vacuum-sealed hot meals, it is easily rolled to wards and rooms. Soups, beverages, ice cream, etc., are stored in insulated steel dispensers and dispensed at the serving point. Tray Cart needs no heat.



below: Heart of the MEALPACK SYSTEM is the sturdy stainless steel CONTAINER. Patented design and construction provide a self-forming vacuum which seals-in the original cooking heat and flavor.

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Less Than
The BEST
Air Conditioning**



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COMPLETE STALE AIR EXHAUST



More and more hospital patients are demanding air conditioned rooms for greater comfort, and closed-window freedom from dirt, pollen and noise.

You can easily satisfy this demand with Yorkaire Room Conditioners—window-sill and console models that require no water or plumbing.

York's sixty-five years of leadership in air conditioning is your guarantee that Yorkaire Room Conditioners are your best bet.

Among York's "firsts" is a completely Hermetically Sealed Refrigerating System—which is totally tamper-proof—and carries a full five-year warranty. That's your assurance that a Yorkaire Room Conditioner is



as dependable, as trouble-free as the most modern home refrigerators.

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In addition, the Yorkaire Room Conditioner provides year round circulation and ventilation of immaculately filtered air—without cooling—whenever desired.

In company with hospital administrators everywhere, you'll discover that you'll quickly amortize the low cost of Yorkaire Room Conditioners with a nominal room surcharge... tap a welcome source of new revenue.

Improve your "problem" rooms... make them your most desirable rooms through year round ventilation, and closed-window freedom from dust, dirt, pollen and street noises. Installing a Yorkaire Room Conditioner is easy, fast. And shifting units from room to room can be accomplished as desired.

Check with your nearest York Representative today for all the facts... and details about amazing low prices. York Corporation, York, Pa.

The big advances come from

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Headquarters for—Refrigeration and Air Conditioning

STAINLESS STEEL

NINE OLD-FASHIONED WOODEN WASHERS were required to handle the load in this laundry before Stainless Steel equipment was installed.



can make a big difference in laundry operations, too



FOUR HENRICI STAINLESS STEEL WASHERS replaced nine wooden machines, with 22% labor saving and a 50% saving in floor space.

STAINLESS STEEL's cost-cutting advantages aren't confined to operating rooms and kitchen areas. From one end of the hospital to the other, you'll find Stainless saving money and making work easier.

Consider your laundry operation, for example. If you are using old-fashioned equipment, you're paying for it in lower efficiency, unnecessary labor and wasted floor space.

In the laundry pictured here, for example, four Stainless Steel washers,

manufactured by the Henrici Laundry Machinery Co., Boston, Mass., replaced nine wooden washers. The switch to more efficient Stainless equipment has saved the labor of two men and reduced the required floor space 50 per cent.

Superintendents recognize U·S·S Stainless Steel as the ideal material for hospital use. This Stainless is so easy to clean and keep clean that it saves time-consuming labor and drudgery in maintaining the high

standards of sanitation that are an absolute requirement for hospitals.

And U·S·S Stainless Steel is unsurpassed for withstanding hard knocks and severe service—it literally lasts a lifetime.

You want the finest possible performance from your Stainless equipment, so always specify "U·S·S Stainless Steel." Your equipment manufacturer probably uses this perfect, service-tested Stainless, but it will pay you to be sure.

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UNITED STATES STEEL SUPPLY COMPANY, WAREHOUSE DISTRIBUTORS, COAST-TO-COAST • UNITED STATES STEEL EXPORT COMPANY, NEW YORK

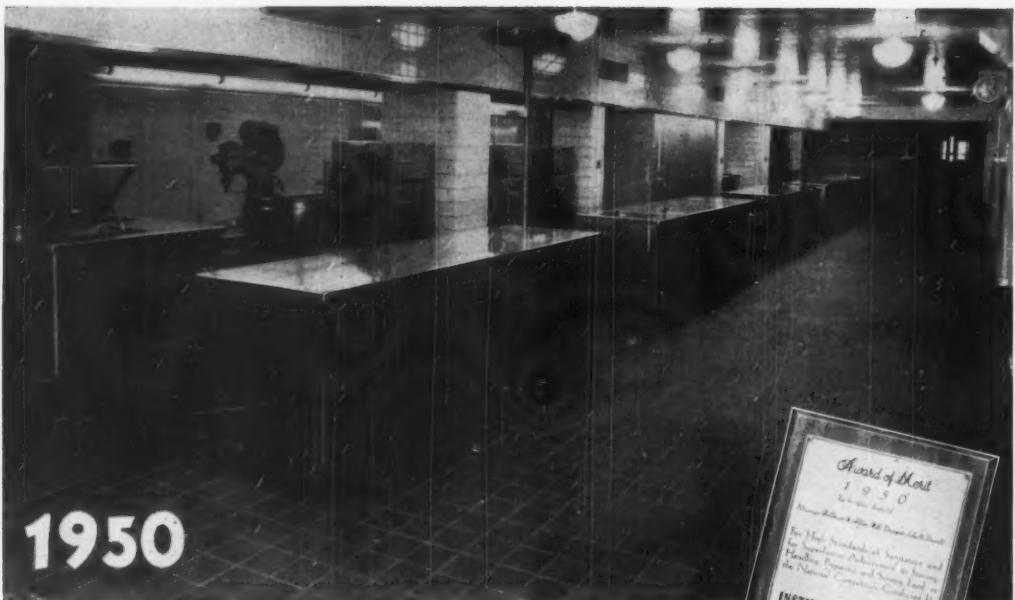
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UNITED STATES STEEL



1950

Hartford Hospital

Architects Coolidge Shepley Bulfinch and Abbott



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- The buyer of food service equipment and his architect will be impressed by the four year consistent parade of awards to Van clients by the successive annual boards of experts of the magazine INSTITUTIONS.
- No matter what kind of food service establishment . . . regardless of size . . . the awards 1947-1950 have given fresh recognition to the high quality of equipment on which Van's name plate appears. The 1950 Awards of Merit to Hartford Hospital, Hartford, and St. Francis Hotel, Canton, indicate again the unusual character of Van's national service to all kinds of institutions.
- If you are planning food service equipment improvements, get the benefit of Van's century of experience.

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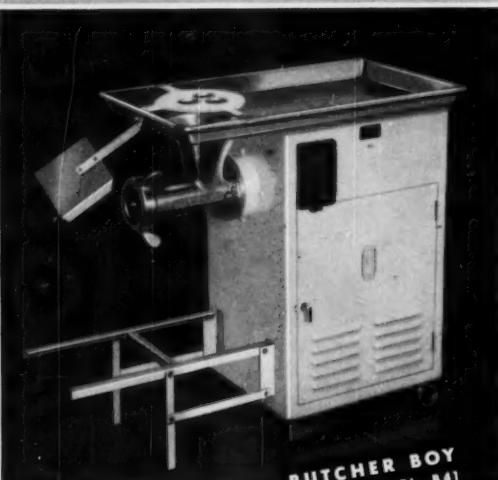
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ENTERPRISE
COUNTER MODEL 2622



BUTCHER BOY
FLOOR MODEL B32

WHATEVER your chopper need, we've a machine to fill it. Model 2622, illustrated, is a grand all-around chopper for the medium to large restaurant or institution. Models 2112 and 2512 are for smaller sized establishments or for use along with a larger chopper. Enterprise 2632 gives high production needed in large institutions or in locker plants. All these choppers have the Enterprise design that cuts meat cleanly without mashing. And they're dependable!

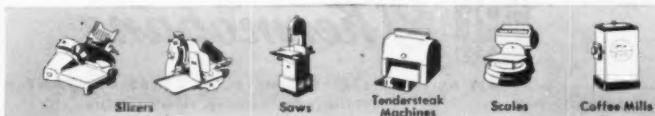
FOR institutions where great quantities of meat are chopped, here are the rugged floor models. Butcher Boy B32 has the power and speed for the large establishment while B41, shown, has the extra capacity for even greater requirements. And for heaviest production are Models B56 and BB56 with 27" by 54" stainless steel pans. The right chopper for the job means lower costs so get data on the complete line from U.S.

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WORLD-WIDE ORGANIZATION WITH U.S.-BERKEL COMPANIES IN
Canada • Argentina • England • Holland • Belgium • Switzerland
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SEND COUPON FOR FULL DETAILS!

U. S. SLICING MACHINE CO., INC.

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An addition which doubled the capacity of Ottawa (Ill.) Arthritis Sanatorium and Diagnostic Clinic is glazed with Thermopane. All winter, patients can sit near the windows without feeling drafts or chilliness. Norman Cook of Ottawa was the architect.



SANATORIUM GETS DRAFT-FREE WINDOWS

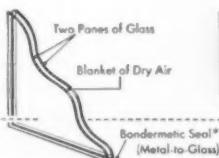
You can provide patients with healthful sunshine without windowpane chill by glazing large openings with Thermopane* insulating glass. Window areas can be almost doubled without increasing heat loss if Thermopane is used instead of single glass.

Thermopane is more than just a window. It is, more correctly, *wall insulation* that you can see through, being two panes of glass with a dry air space between. Besides providing patients with an outdoor view and abundant daylight, Thermopane makes possible the

trend toward larger glass areas without increasing heating capacity and fuel consumption.

The economies of window walls, also, include the fact that they require no exterior masonry nor interior furring, plaster or paint. All these economies add up to the fact that Thermopane is an economical wall material for hospitals. To obtain more details on how Thermopane is being used in hospitals, write for our Thermopane literature and a 24-page, illustrated brochure "Daylighting for Hospitals". *®

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Congratulations!

to Masonic Home, Zenith, Wash.,

on its Compact,
Highly Efficient,
Laundry Department

PROBLEM: This Masonic Home, which cares for 160 elderly persons, questioned whether its clean linen problem was being handled most efficiently and economically.

SOLUTION: Our Laundry Advisor was requested to make a thorough study and submit all findings. His report listed actual benefits to be obtained by installation of a small, efficiently equipped laundry department. Masonic Home then decided to install the laundry according to specifications supplied by the Laundry Advisor.

RESULTS: The Superintendent reports savings of \$833 during first 3 months of operation. Other benefits include "better quality work", "faster return of linens to service" and "smaller linen inventory."

Hospitals, large or small, are invited to discuss their laundry problems with our Laundry Advisor. No obligation. WRITE TODAY.

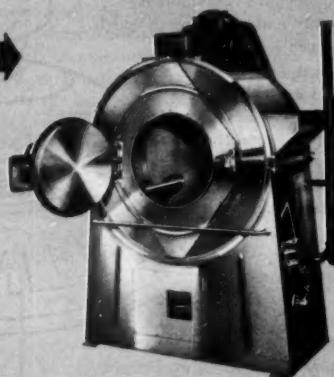
Your hospital will benefit by selecting from our complete line of most advanced and productive hospital laundry equipment.

REMEMBER . . .
Every department of the hospital
depends on the laundry!



All linens, blankets, curtains, etc., are laundered in this compact laundry consisting of 2-Roll STREAMLINE Flatwork Ironer, ZONE-AIR Drying Tumbler, Solid Curb Extractor, 25-lb. and 50-lb. CASCADE End-Loading Washers.

CASCADE End-Loading Washer. Masonic Home uses two of these late-type washers, one 50-lb., one 25-lb. dry wt. capacity. Famous CASCADE through-and-through washing action gently, yet thoroughly, washes linens sterile-clean with amazing economy. Washers feature extremely simple operation; are sturdily constructed of Monel metal for dependable service.



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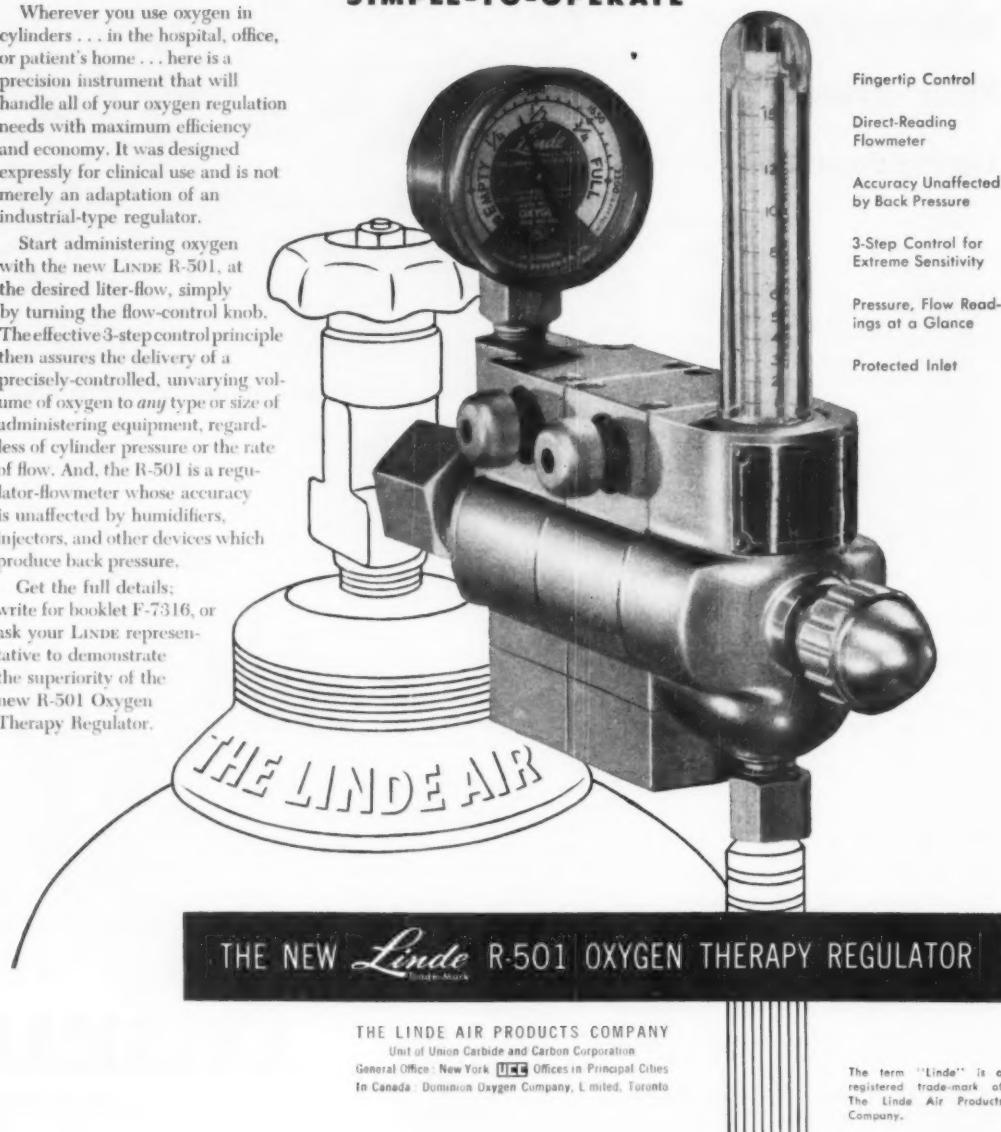
NOW... a truly clinical regulator for Oxygen Therapy

DEPENDABLE
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SIMPLE-TO-OPERATE

Wherever you use oxygen in cylinders . . . in the hospital, office, or patient's home . . . here is a precision instrument that will handle all of your oxygen regulation needs with maximum efficiency and economy. It was designed expressly for clinical use and is not merely an adaptation of an industrial-type regulator.

Start administering oxygen with the new LINDE R-501, at the desired liter-flow, simply by turning the flow-control knob. The effective 3-step control principle then assures the delivery of a precisely-controlled, unvarying volume of oxygen to *any* type or size of administering equipment, regardless of cylinder pressure or the rate of flow. And, the R-501 is a regulator-flowmeter whose accuracy is unaffected by humidifiers, injectors, and other devices which produce back pressure.

Get the full details; write for booklet F-7316, or ask your LINDE representative to demonstrate the superiority of the new R-501 Oxygen Therapy Regulator.



THE NEW *Linde* R-501 OXYGEN THERAPY REGULATOR

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Unit of Union Carbide and Carbon Corporation
General Office: New York UCC Offices in Principal Cities
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The term "Linde" is a registered trade-mark of The Linde Air Products Company.

Small Hospital Questions

Central Oxygen System

Question: We have been giving serious thought to the installation of a system for piping oxygen directly to the patients' rooms in the new addition to our hospital. Can you refer us to an authority who can give expert advice on this subject?—W.A.H., Pa.

ANSWER: The installation of a central oxygen system providing outlets in patients' rooms has become increasingly common in recent years with the growing use of oxygen therapy for a number of medical purposes. To some extent, of course, the advisability of such a central installation must depend on the ability of the hospital to cope with the installation cost, the nature of medical practice in the hospital and other factors that vary from institution to institution. In general, however, it is safe to say that such an installation should be given most serious consideration for every new hospital facility now being built—with the expectation that favorable judgment will ensue in a large number of cases. Expert advice on specific projects may always be obtained from the engineering staffs of companies that manufacture and distribute oxygen equipment.

Charge for Wassermann Test

Question: If a hospital establishes a policy of requiring a Wassermann test on all patients, should the patient be required to pay for it?—A.A.H., Calif.

ANSWER: It is impossible to avoid some complaint from patients who will protest that they never ordered the procedure and therefore refuse to pay for it. However, in most such cases it is possible to persuade the patient that the procedure was undertaken in his interest so that payment will be forthcoming without difficulty. Certainly, it is in order for the hospital to make a charge for this service and it is increasingly the practice for Wassermann tests to be included as part of the routine undertaken for all admissions.

Hiring Clerical Help

Question: Is there any correlation between educational training and clerical efficiency? How important is educational background as a factor in the hiring of new clerical help for a business office?—R.T., Mass.

ANSWER: After using pre-employment tests for more than a year, the University of Florida decided to make a statistical study to find out what gen-

eral conclusions might be obtained. Based upon test scores of about 1000 applicants and data supplied by the personnel office, this study was recently completed with results that may be of interest to other personnel officers.

Younger persons with no more than high school education usually should be placed in strictly clerical jobs. Those positions involving typing and language skills might better be filled by older persons with greater amounts of schooling or experience.

The more education the better the scores in all tests except typing. There is little or no correlation between education and typing ability. To put this another way, typing is a manual skill that may or may not have much relationship to abstract intelligence. Our original assumption was that persons with high clerical aptitude scores could master the typing requirements of any job if given the chance, but this has not proved to be the case either from actual cases or from this statistical study.

Typing speed and accuracy are closely related. The applicant who affirms that she is a slow typist, but accurate, may be viewed with considerable skepticism. To say the least, she is an exception to the rule.

There is a high correlation between vocabulary, covering the knowledge of words, and language skills, covering the mechanics of English, such as spelling and punctuation. As might be expected, both vocabulary and language skill increase with years of schooling, the mean range varying from the 64th to the 88th

percentile in vocabulary and the 81st to the 97th percentile in language skills from high school graduation to college graduation.

Mean performance on all tests except typing and shorthand decreases with age, while variability increases with age. This means we find both our very lowest and our very best applicants in the group 32 years and more in age. Particularly in office checking does this group show great variability. The conclusion is that except in rare cases older persons should probably not be placed on jobs where the trait measured by office checking is of primary importance. A younger person does this type of work faster. Older persons do better in jobs requiring the use of words, arithmetic and typing. As a matter of fact, typing scores seem to improve somewhat with age.—B. W. AMES, director, nonacademic personnel, University of Florida.

Fire Safety Training

Question: What methods are recommended for training hospital employees in their responsibilities in case of fire and making certain specific fire duties are thoroughly understood?—T.Y.O., Me.

ANSWER: Because of the upsetting effect on patients, fire drills such as those commonly used in schools and other institutions are not practicable for hospitals with the possible exception of sections in which all patients are ambulatory. Therefore, training and instruction in fire responsibility become a supervisory function. Each department of the hospital should have a written statement covering specific duties of all classifications of employees with reference to fire inspection, reporting and functions in case of departmental or general fire alarm.

Properly, this subject should be systematically scheduled for discussion at employee meetings if these are held, or for routine discussion in interviews between supervisors and employees, department heads and supervisors and, of course, administrator and department heads.

Every hospital should have a written statement of fire rules and regulations for posting on employee and staff bulletin boards. These should be as clear and terse as possible to avoid confusion or misunderstanding.

Conducted by Jewell W. Thrasher,
R.N., Frazier-Ellis Hospital, Dothan,
Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

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SANACOUSTIC* CEILINGS fill the R_x!

TO GIVE patients the *rest and quiet* needed for speedier recovery, the modern hospital relies on noise control. One of the most effective ways to eliminate harmful and disturbing noise is to install Johns-Manville Sanacoustic Ceilings.

Sanacoustic Ceilings are not only the most efficient available, but they are also sanitary and noncombustible. They are made of perforated metal panels with a

baked-enamel finish, backed up with a fireproof sound-absorbing element. They're so easy to clean you save on maintenance. And they can be painted and repainted without loss of their acoustical efficiency.

Reception rooms and cafeterias, corridors and lobbies, nurseries and wards are among the noise centers especially in need of "noise-quieting" Sanacoustic.

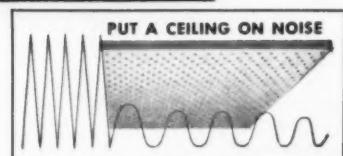
For areas subject to continuous and excessive moisture, such as diet kitchens, utility rooms, dish-washing rooms, you can choose our perforated Transite® Asbestos Panels. Write for free book on Sound Control, or an estimate, to Johns-Manville, Box 290, New York 16, New York.

*Reg. U. S. Pat. Off.



Johns-Manville SANACOUSTIC CEILINGS

48



The MODERN HOSPITAL



Shown above: Simmons Hospital Room No. 71. Color Scheme No. 7201 Dusty Rose with Shell. Self-Adjusting Bed, H-817-1-L-190; Dresser Base, F-180-3, with Mirror FM-62; Bedside Cabinets, F-480-F; Arm Chair, F-763; Chair, F-711; Footstool, F-909-R; Single Pedestal Overbed Table F-882.



This cleverly designed overbed table can be lowered to 29 $\frac{1}{4}$ inches for use by patient in chair. Maximum height of overbed table is 44 $\frac{3}{4}$ inches. Double binged top permits use from either side of bed. Easily removed inset tray provides space for toilet articles, writing materials and other patient necessities. Order No. F-882.

Display Rooms: Chicago 54, Merchandise Mart Plaza
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Atlanta 1, 353 Jones Avenue, N. W.
San Francisco 11, 295 Bay Street

Simmons skill works magic

-in Color, Comfort and Steel

There's magic in this new hospital room ensemble...in its soft, soothing colors to help restore health faster...in the way its mechanical features provide greater comfort and convenience for patients—less work for doctors and nurses. And there's magic in the way sturdy steel construction resists wear...defies fire!

The bed is Simmons famed Self-Adjusting Model that helps patients help themselves. The ingenious overbed table serves as table, book rest and vanity! The new Simfast finish in Dusty Rose with Shell resists damage from spilled liquids, medicine, heat and cold.

Here is beauty, convenience and long life to satisfy the most practical hospital administrator.

Metal furniture and sleep equipment for every hospital need.



Write for new catalog
of Simmons' complete
line of hospital equipment.

Simmons Company

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INCUBATORS' WORTH
OF EXPERIENCE
STANDS BEHIND EVERY
ARMSTRONG X-4
BABY INCUBATOR**



The Armstrong X-4 Baby Incubator was the first Baby Incubator to merit all three of these "awards".

● Every feature of the Armstrong X-4 Baby Incubator has been hospital-tested and time-proven, not in just a few hospitals or for a few months, but in thousands of hospitals throughout the world, many of them since 1943. Literally, hundreds of thousands of new borns and prematures have made their start in life through the facilities of an Armstrong X-4.

Every Armstrong X-4 is simple to operate and time has proven this simplicity to be both safe and effective.

There are only 3 moving parts in the Armstrong X-4—the two ventilators and the one control dial.

Finally, the X-4 is low in first cost and equally low in operating cost. Send for complete descriptive literature.

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Lately I've been seeing a lot of Baby Incubator advertising and reading a confusion of claims for incubators—some of them sound and some of them silly. Seems to me to be a lot of words about a simple subject. Where down in a lot of claims.

Let's forget claims, however, and use our own good common sense — "Incubator sense" you might call it. There are just 3 things any good Incubator can do—provide heat, humidity and oxygen. When you have how to provide simple, safe and accurately controlled heat; how to provide adequate humidity without complicated controls; and how to provide a safe container for oxygen. Anything more than this is up to the physician and the nurse.

Buy these three things in an Incubator and buy them at the lowest price possible. If there is experience back of the design, you don't need to worry too much about studying queer or unusual claims. Back of every Armstrong X-4 Baby Incubator is over 9,000 incubators' worth of experience—and the price is still low.

Cordially yours,
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"Back of every Armstrong X-4 Baby Incubator is over 9,000 incubators' worth of experience."

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Looking Forward

No Third Man Theme

SOME members of the hospitals-are-practicing-medicine school of thought are trying to make house with the recent Ohio supreme court decision in the case of the Cleveland Osteopathic Hospital *v.* Zangerle *et al.* The court upheld a ruling of the Board of Tax Appeals denying the hospital tax exemption on the ground that it was not an institution "used exclusively for charitable purposes"—in the qualifying phrase of Ohio's law. Evidence introduced at the Board of Appeals hearing on the application for exemption disclosed that the hospital employed six or seven osteopaths and paid them salaries that were substantially less than the amounts charged hospital patients for their services. In considering whether or not the hospital could be regarded as "exclusively charitable" the court had obviously found it difficult to ignore these and other "profits" it had earned during the year for which exemption was sought.

A few observers have suggested that the Ohio decision means all hospitals employing physicians on salaries and earning a surplus on medical services are jeopardizing their tax exempt status. This is absurd for a number of reasons. The language of the decision itself makes it clear that the court was concerned only with Ohio law. "Cases from other jurisdictions are not ordinarily very helpful," the court stated, "because, more often than not, the tax exemption provisions under which they were decided differ materially from the provisions on the same general subject obtaining in this state." The court also warned that there is no general rule dispositive of whether a hospital is being conducted exclusively as a charitable project. Rather: "All the facts in each case must be assembled and examined in their entirety, and the substance of the scheme or plan of operation exhibited thereby will determine whether the institution involved is entitled to have its property freed from taxes."

Furthermore, the decision makes it plain that the court was more concerned with the existence of the so-called profits than with the manner in which they were earned. There is no indication that the decision was significantly influenced by the fact that surpluses

appeared in the professional service account, as opposed to food service, pharmacy, room and board or any other service. The thinking from which the decision emerged is probably revealed most clearly in this passage from the text of the majority opinion: "The adjective 'charitable' attached to 'hospital' conveys the idea of a place where service and assistance are given to the sick, injured and ailing, with open doors and benevolent concern for afflicted souls who lack the ability to pay for the attentions they receive. . . . In accordance with the concept of an organization devoted exclusively to charitable purposes, a hospital to qualify as a charitable institution the property of which is exempt from taxation should have as an important objective the care of the poor, needy and distressed who are unable to pay, although the fact that it admits and ministers to a number of pay patients will not necessarily destroy its charitable character."

It should be noted that three of seven justices dissented from the decision. If there is any lesson for hospitals in this case, it has nothing to do with the radiology-pathology-anesthesiology theme song that the hospital is an unwanted third man in the doctor-patient relationship.

Music, Music, Music

AS ORIGINALLY reported in The MODERN HOSPITAL a year ago, experiments with surgical music at the University of Chicago Clinics have proved successful, and the university now announces a permanent installation. Patients at the university's new Goldblatt Memorial Hospital will have a choice of classical, semi-classical and popular music to diminish their apprehension during the anesthetic period and, in case of local and spinal anesthesia, during the operation itself. Incidentally, the university states, with those who know incisions best, it's Victor Herbert, two to one.

"Music is a tremendous help in lessening the fear, strain and tension of the patient," the chief surgeon commented. Anesthetists and nurses confirmed this observation, and psychiatrists added their blessing to the

project. It remained only for the patients themselves to give voice, and, happily, their tone was also lyrical. In fact, it is reported, some patients became so entranced by the musical score as to express astonishment that the operation was over—a circumstance that loses impressiveness, to be sure, when one remembers the postoperative patient's tendency to forget what year it is.

Nevertheless, reading the university's announcement one can easily visualize the hospital meeting of the future: Exhibitors will present auditions with the nation's leading orchestras and vocalists, and no convention program will be complete without its panel discussion on the best technic for blending ether and Offenbach. Instead of trading clinical anecdotes and triumphs, tomorrow's surgeons will sit around the doctors' lounge arguing the comparative efficacy of pentothal and polyphony for hysterectomies, and along with his other troubles the hospital administrator must be prepared to deal with the irate patient who asked for the Fuermann-Heifetz-Rubinstein recording of the *Archduke Trio* and got Muggsy Spanier doing *Honeysuckle Rose*.

Better he should swallow a sponge.

Score and Stature

THE measures of a ballplayer's ability are his batting and fielding averages. A salesman is judged by the volume of his sales. The doctor's performance stands on the number of his patients who improve and get well, and the success of a profit-making enterprise is related in terms of the profits it makes.

Unfortunately, there is no such simple yardstick with which to measure the work of the hospital administrator. There are no batting or fielding averages, no sales and no profits in the hospital. The volume of business is determined by the abilities of the staff and by the sickness rate and general economic condition of the community. If revenues exceed expenses in the hospital, it may mean that rates are too high or service is poor—circumstances which would reflect discredit instead of glory on the management. If expenses exceed revenues in the hospital, it may mean that the hospital has assumed obligations for care of indigents beyond the willingness or ability of other agencies in the community to pay for such care—a circumstance which may reflect credit instead of blame on the management.

How, then, can the administrator's performance be evaluated? Crude as the method is, there is no better way than to assume that a good hospital must reflect the ability of its manager, while a poor one condemns its head. What is a good hospital? Obviously, there are imponderables in this consideration, too, but here, at least, some definitions have been emerging in recent years to make judgment possible if not ever simple or wholly accurate.

First of all, certainly, a good hospital is one in which good medical care is rendered. This is not the responsibility of the administrator, to be sure, but it is the administrator's business to know what good medical

care is, and it follows that a good administrator would not remain long in a hospital where medical quality was poor and showed no signs of getting better. In the medical audit, the staff, administrator and trustees have a means of measuring medical quality—not precise or infallible but generally satisfactory for comparing the performance of groups of doctors over long periods with accepted standards for various classifications of service. In a good hospital the staff audits its performance or the administrator and trustees see that such an audit is made.

If good medical care is the first essential of a good hospital, the second is good nursing service. There are standards for measuring hospital nursing service quantitatively, and the good hospital uses them. Qualitatively, however, nursing service must be judged by the satisfaction it affords doctors and patients. In the good hospital, some systematic means of testing staff and patient satisfaction will be producing consistently creditable reports. Similarly, the good hospital will know that its meals—always an index of quality in the patient's mind—are evoking a satisfactory response.

In a good hospital, finally, good medical, nursing and dietary service will never result from extravagance. "Buy the best and charge accordingly" may be good business for a hotel, but the hospital's responsibility cuts deeper and includes an obligation to deliver service at the lowest possible cost consistent with the means of its patient constituency. Hospital costs are measurable today by standard accounting methods. Understood in relation to the nature and amount of the service that is rendered, costs are a reliable guide for measuring hospital performance.

All these and other phases of hospital operation are included in the point-rating system now being used to evaluate hospitals for approval by the American College of Surgeons. Many hospitals are finding the system helpful and are using it to measure performance for purposes of self enlightenment and improvement. While it cannot be said in fairness that an administrator whose hospital has a high score in the point-rating system is invariably a better administrator than one whose hospital has a low score, this is the judgment that is likely to stand until the latter, like a ballplayer with a poor batting average, can justify his standing.

Of course, neither the point score nor any other valuation system will measure the hospital's spiritual worth—the degree to which its people are genuinely devoted to the sick and suffering as fellow human beings in need of comfort. To the patient and his family, however, the spirit of the hospital emerges subtly but unmistakably in many different ways. Where there is real compassion the hospital is judged good. Without compassion, technical and professional performance at best can have only shallow excellence. As it was in the time of Hippocrates, care of the sick today is still more art than science. Not more than the parts can exceed the whole can the hospital administrator's knowledge and abilities exceed the stature of his soul.



To Get **RECRUITMENT RESULTS**

local effort must be added to national promotion

RICHARD D. VANDERWARKER

Director
Passavant Memorial Hospital
Chicago

LAST spring when we announced the establishment of the James Ward Thorne School of Nursing of Passavant Memorial Hospital, newspaper editorials and hospital trade publications gave us a great deal of praise for taking action to help reduce the nationwide shortage of nurses. This praise, however, was more disturbing than encouraging. Let me quote a portion of an article from the Illinois Hospital Association bulletin and you'll see what I mean:

Condensed from a paper presented at the Tri-State Hospital Assembly, May 1950.

"Real optimism is demonstrated by Passavant Memorial Hospital of Chicago in announcing plans to establish a school of nursing which will admit its first class next fall. . . . In this connection it is interesting to note that six Chicago hospitals have closed their schools of nursing within the last three years while four downstate hospitals have done so within the last year."

The article then went on to list the

names of the six hospitals which were forced to close their schools of nursing.

The *Chicago Sun-Times* had this to say on its editorial page: "In view of the desperate need for nurses Passavant Hospital is to be congratulated for its foresight and courage in opening a new nursing school while other hospitals are closing theirs." You can well imagine, therefore, the misgivings and anxiety with which our director of nursing and I approached this task in view of the discouraging experience of other hospitals.

However, it all turned out very

satisfactorily. We received a large number of applications and accepted our maximum quota of 51 students in the charter class, which was admitted 1st September.

Our recruitment program was founded on what we believe to be a fact which, although fundamental, is frequently overlooked in the confusion of preparing the many tools and devices needed to conduct a good nurse recruitment campaign. This is our belief:

A great many of the girls who are graduated from high schools in the United States each year go into careers other than nursing although they wanted to be nurses or could easily have been interested in enrolling in a school of nursing.

The reason that they did not enroll in a nursing school in most cases is the fact that no one crystallized their decision and placed an application in their hands. In the business world we know this as "closing the sale."

Last spring this was an impression rather than a belief and we took the trouble to make a short survey. While only superficial, it was enough to indicate that nursing school literature does not often penetrate down through high school principals and student counselors to the students themselves.

THEY ARE STILL GOOD PROSPECTS

We learned that many girls who wished to find out about nursing schools did not know where to write for information. Any of these girls, of course, could have found out by making inquiries at any one of a number of sources, but this was simply too much trouble. This does not mean that these girls would not be fine prospects. It is a human weakness to put off until too late any action so voluntary as writing for any kind of an application. If life insurance salesmen were to wait until all the people who really wanted insurance came to them, their companies would soon be bankrupt.

The student nurse recruitment campaign conducted by the American Hospital Association in conjunction with the Advertising Council and the efforts of the Committee on Careers in Nursing have been important factors in stimulating interest among young women in nursing careers. The problem, then, is to capitalize on this interest and actually to enroll those who are qualified.

This thought is not new. It was



Wanda Langum, instructor in foods, nutrition and cookery, and students of the James Ward Thorne School of Nursing at work in the nutrition laboratory.

expressed in the American Hospital Association's kit, "A Public Relations Guide for Hospitals and Schools of Nursing," in its first paragraph, which said: "Let's face it. Even with the support of a one million dollar national promotional program the job of recruiting young women still falls on *your* shoulders. It's *your* responsibility, and all the display advertising, radio publicity and editorial support in the nation won't change the picture. Each school or hospital will succeed or fail according to how effectively the enrollment drive in each community is conducted. If you will accept this fact, then you are ready to meet the problem."

Well, are we meeting this problem? Last year there were graduated from the high schools of the United States 639,000 young women. Only 43,600 of these graduates entered schools of nursing during the same period. There remain each year, therefore, more than half a million girls who are prospects.

I am convinced that a great many of these girls who did not enter schools of nursing were mentally conditioned toward nursing as a career, but the failure occurred at the local level, where we neglected to put the application blanks in the hands of the live prospects.

Before I tell you specifically what was done at Passavant, let me digress for just a moment to stress the seriousness of this subject. It has been discussed so much and written about so

often that some of us may be bored with it, but we cannot permit this to happen. It is one of the most serious problems, perhaps the most serious problem, confronting hospitals today. The importance of a continuing recruitment program must constantly be stressed if each nursing school is to have at all times full complement of students, as it must if we are to meet the health needs of our citizens. How many nursing directors are able to staff their hospitals well enough to give proper patient care? Many hospitals, too, have beds that are unoccupied because of lack of nurses. We must face this problem and, frankly, I think the problem is one of our own mental attitude rather than any real difficulty in getting nursing students.

PLAY UP THE ADVANTAGES

Perhaps we are too defensive about nursing. Let's take advantage of the fact that nursing is now a far better career than it ever was. A salary survey indicates that working hours are decreasing and salaries have risen to new highs. They are now comparable to those of similar careers for women. To put it another way, when you convince a girl that she should follow this career, you are doing her a real favor.

Not only are we faced with a shortage of nurses at present, but we all know that the need is going to become increasingly acute. Advances in medical science, new hospital construction, and the expansion of health services



Betty Schrock, assistant nursing arts instructor, demonstrates some techniques to a group of new students in the nursing arts laboratory of the hospital.

are all factors which will accentuate and accelerate the demand for nurses.

As proof of this trend, in 1910 there was one nurse for each 1116 persons in the country; in 1946 there was one nurse for every 316 persons, and it is estimated that in 1960 the need will be one nurse for each 207 persons.

One year ago, we determined to do what we could do to alleviate the nursing shortage both because we felt the need ourselves and because we wanted to round out Passavant's teaching program. While we had the advantage of being a teaching hospital, we had many problems to face in recruiting our nursing students. The recruitment program, first of all, got off to a late start. The faculty was not then complete and nursing classrooms and dietetics laboratories were still in the planning stage. With an unknown school we were competing with some excellent, well known and well established nursing schools. There were 37 approved nursing schools in the city of Chicago. To use a baseball term, we had no farm system because Passavant has no church affiliation and no organized alumnae group.

To overcome these obstacles we first made a survey. It convinced us that there were many girls, favorably predisposed toward nursing careers, who could be signed up. We then employed a number of the devices recommended by the American Hospital Association and added a few of our own. This is what we learned: Each me-

dium employed—contacts with schools, visits to schools, newspaper and radio publicity—paid off by producing at least one finally accepted student. This was determined through a questionnaire completed by the students on their first day of school.

The same questionnaire disclosed another interesting point: The factors influencing the students' choice of a nursing school and of a nursing career were divided into two categories: (1) persons and (2) planned events and publicity. In the first category we found that the persons who most influence the students' choice rank in the following order of importance: relatives, graduate nurses, doctors, student nurses, schoolteachers, priests and ministers. This accentuates the importance of employing a variety of recruitment methods. Not all of the effort should be aimed at the student herself. Some must be beamed at the people who will influence her choice. An attempt should be made to enlist doctors and graduate nurses to assist in the recruitment program.

This portion of the survey paralleled the results found in a poll conducted by the Indiana State Nurses' Association as reported in the April 1949 issue of the *American Journal of Nursing*. The Indiana survey ranked visits to hospitals and career talks given in schools or before groups as the most productive enrollment mediums. According to this poll, radio and newspaper publicity was least effective.

However, I strongly suspect that this is because radio and newspaper publicity was not used to any great extent. I am sure that had it been employed, its importance would have been much greater. This is borne out by our own experience.

If you are planning to utilize radio broadcasting facilities I recommend that you study the most recent American Hospital Association public relations bulletin. It is entitled "Telling Your Hospital's Story on the Radio." This is extremely informative and is an excellent guide to determine facts about listeners, types of programs available, writing radio script, besides containing many other helpful suggestions. In addition, if you are in an area where television is available, this, too, has great possibilities.

If you have studied the American Hospital Association's nurse recruitment kits it is possible that you may be overwhelmed by the great number of devices suggested, but I'd like to point out that it is not necessary to employ *all* of them in any one campaign. I should suggest that you select those you can use most advantageously in your local area. In some cases you may use only a few of the suggestions, secure in the knowledge that each of them will be productive to a certain extent.

However, bear in mind that repetition of these devices annually may cause them to become stale and lose their effectiveness. There are many other effective devices which can be substituted to maintain the vitality of the program.

EXPERT ASSISTANCE IS NEEDED

Expert assistance in planning and developing these devices is available to all, whether it is paid or voluntary. It is hard to conceive of any town in this area in which there is not one or more industries which are producing consumer goods and therefore maintain a staff of advertising and public relations personnel. Nursing has great popular appeal. These professionals, I am sure, would gladly lend their experience and skill in aiding you to prepare your recruitment program.

Even if it is conceivable that this help is unobtainable, these recruitment kits can be utilized by you personally. They are sufficiently complete and simplified for any of us to use. Not only is each device of value in itself, but it is the cumulative effect of a well rounded program which produces the students.



Tours of the hospital are an important aid in enrolling student nurses. Girl at right visited hospital as result of recruitment publicity.

It has been found very helpful *not* to gear your program solely to high school seniors. Great future benefit may be derived from interesting the younger girls in high school in nursing as a career. The Michigan Nursing Center Association believes that future nurses' clubs offer a most effective recruitment device and at the same time prove their usefulness in high school health programs. The Hackley Hospital in Muskegon, Mich., has dramatized this principle, and its plan is quite intriguing. In Muskegon the high school freshmen, sophomores and juniors sign an agreement which states they wish to become student pledges. The girls wear a pledge pin signifying their intent to enter the hospital school of nursing when they have completed the usual requirements. I am sure they wear this pin proudly, and that it helps to crystallize their desire to become nurses. In addition, they become living

advertisements for the school of nursing. Of course, this pledge can be revoked if the girl changes her mind, but the effectiveness of the plan is obvious.

A recruitment organization is a helpful device. An article, "How to Get Nurses Galore," in the February 1950 *Reader's Digest* described the effective organization built by the Methodist Hospital in Indianapolis. Although this was statewide, it is conceivable that similar local organizations can be built on the structure of existing civic groups. The additional advantage of these organizations is that you have people in the field who not only sell girls on nursing as a career but also can place the applications in their hands and sign them up.

This brings us back to the keynote of this discussion: there are students available if we will make sufficient effort to "close the sale."

Recruitment Starts in High School

ONE of the most successful methods we have used to encourage girls to enter nurse's training has truly borne fruit for our hospital.

In 1944 when employees were hard to find, and nurses were at a premium, we sought help from high school girls. They worked after school, on weekends, and during summer vacations. The girls filled a definite need in our service and some of them became interested in nurse's training through their contact with the hospital.

With the cooperation of the two high school faculties in Sheboygan, Wis., a community health course was set up in the high schools. The hospital resources are utilized for laboratory work for which the students are given academic credit.

Each year the students who are interested in nursing enroll in the "Fundamentals of Nursing" class and spend 20 hours of their semester working in the hospital after they have received class instruction at school. At the end of the semester the girls are given a dinner by the hospital attended by the superintendent of nurses. At this time they are given an opportunity to ask questions, and many of them offer suggestions as to how their course can be made more interesting.

These girls become acquainted with our hospital and, when they finish their nursing course, come back to work as registered nurses. We now have several nurses on our staff who received their first knowledge of nursing here as high school students.

Some girls who enter the class drop out after a few classes and others who finish the course are convinced they want no more to do with a hospital. The course acts as a "proving ground" and many times has kept a girl from entering nurse's training only to find she isn't interested in the work.

This course also has value as a public relations program. These girls usually become so interested in this hospital they are proud to tell their friends and relatives about their work. They feel they are a part of the organization and as such have the responsibility of rendering good service and keeping the standards of the hospital high.—MRS. GERTRUDE OLSEN, superintendent, Sheboygan Memorial Hospital, Inc., Sheboygan, Wis.

A day in the life of a

RECORD LIBRARIAN

MRS. CATHERINE M. LANGER, R.R.L.

Medical Record Librarian
Asbury Hospital
Minneapolis

IT IS my heartfelt belief that every hospital administrator, intern and student nurse should be made to spend at least a month in the record room. I realize that this belief will probably never see fulfillment, so for the sake of hospital administrators especially, I write this little article, with the hope that somehow my fellow strugglers in the medical records profession will be understood a little more, and not just tolerated as a necessary evil.

Will you join us on a typical day in any record room?

Miss Jones arrives at 9 a.m., fresh and happy and ready to start in with some insurance papers that *must* get out today. Her assistant has been there an hour already, and has written in the admissions for the day before, checked the census for the preceding day, and pulled the discharge cards.

"Miss Jones, I can't find a couple of cards. I've looked everywhere for them, and the front office doesn't have them either."

THEY TURNED UP IN THE "N's"

"You mean discharges?" Miss Jones asks in alarm. Such being the case, she, too, looks in the box, at both the admissions and those already discharged, to see if the cards had somehow been misfiled, which *does* happen occasionally. There is another box holding cards that are all ready to file in the master file, if either of them ever find a spare minute. The missing cards aren't there, either. So precious minutes are wasted looking for the most important thing (well, almost) in the record room—the patients' index cards. They are eventually found, of course. Someone put all the M's in the N's, or something of the sort.

That taken care of, Miss Jones pulls out her typewriter and gets out the insurance folder. The mail is delivered.

One letter looks rather important, so she opens it first. It is an inquiry from a doctor in another town concerning a patient who is to have surgery very soon, and he wants to know just what was done at a previous operation. That wouldn't be so bad, but the patient doesn't know exactly when she was hospitalized; she believes it was in October or November of 1920; but then it might have been in the spring of the following year!

Miss Jones looks longingly at her assistant's back—but she is so busy; she won't ask her to go look for that old chart. She'll go herself. It would be in the house next door. There are no cards for that many years ago, so she will have to look in the old, old patients' registers. Stoically she climbs the ladder, pulls down book after heavy book; the one for 1920 must be on the bottom. She thumbs through the pages for October and November; such a patient was never registered at that time. Maybe it was September or December. She thumbs through those pages until her eyes are swimming. Now, where was that book for 1921? She should have kept it out when she had it a few minutes ago. She finally finds the patient, not in May or June or March or April of 1921, but in October of 1921! She hopes to get information enough

from the register to answer the doctor's letter, but record clerks in 1921 believed in being brief, to say the least. So she must get the chart, after all.

The "dungeon" is pretty dark; Miss Jones contends it would be a wonderful place for a murder. She is going to write a book some day, entitled "Murder in the Dungeon." The victim will naturally be the medical record librarian, her murderer will be one of the doctors who simply got tired of hearing her beg him to complete his charts.

NOW, SHE NEEDS A BATH

Not only is the "dungeon" dark, it is very dirty. Miss Jones has taken along pencil and paper and writes down the desired information from the chart, which, like the old register, is very brief. Doctors were no better than record clerks then—or now, Miss Jones reflects.

She has the information, but she also has a very dirty lab coat. Did she get her others back from the laundry yet?

She scrubs her hands and arms and wishes she could take a bath. She settles herself comfortably at her typewriter. The telephone rings.

"This is Black and White, undertakers. Is the death certificate for Mr. Brown signed?" She hadn't even had time to ask if there had been a death. "I'll check. Just a minute." No, the certificate had not been signed. However, the doctor is in the house, and she will see that he signs it right away. "You can come over after the body."

She rushes around like mad to get the doctor to sign the death certificate. Then she rips out of the typewriter the letter she had already started to the other doctor, and hurriedly types up and signs her part of the certificate. She is just finishing when she looks up to see a man standing at her desk.



"Is the certificate for Mr. Brown ready?"

She brushes the perspiration from her brow and hands the certificate to him. He checks it over very carefully, and she is so happy that neither she nor the doctor has made some slight error and the certificate does not have to be retyped.

Back goes the first letter into the typewriter, and a few minutes later, as she is signing it, she looks up to see a man standing in the doorway, looking inquiringly first at her assistant and then at her. Seeing her watching him, he steps to her desk.

"Is it ready?" he asks, almost belligerently.

Somewhat blankly, "Is what ready?"

"My insurance paper. I left it here yesterday, and they said it would be ready today."

Miss Jones used to ask who "they" were, but she refrains now.

IT TAKES SO LONG TO EXPLAIN

"What is your name?" She tries to be sweet, but she wishes people would realize that of all the 600 discharges per month, almost 600 of them have hospital insurance with almost 600 different insurance companies. Upon learning his name, she also finds that the chart is incomplete. It takes a good many minutes to explain to the man what a chart is, why it must be complete before an insurance paper is filled out, why she would rather send it direct to the insurance company or the employer, and why this hospital is no different than any other hospital, and—oh, well, the man finally leaves, mumbling to himself.

Her assistant is taking dictation from the dictating machine. "Miss Jones, can you make out this word?"

Miss Jones puts the earphones to her ears. She listens intently. Everything is quite plainly spoken, but this particular word is slurred, and it takes minutes before she grasps it finally.

Her favorite doctor (medical record librarians are not supposed to have such things) comes in. "I'll buy you a coke," he offers.

She hates to say she is too busy. Besides, she feels the need of a "coke" in the worst way just now. So out to the machine they go, and drink their refreshments out in the hall. Just about this time the hospital administrator happens to go by, and of course he thinks his record librarian must be pretty well caught up with her work if she has time to drink a "coke."



from its cradle and leave it off the rest of the day.

"Say, doctor had a patient last Friday—did surgery on him—and he told me his name, but I guess I didn't get it right. Can you help me?"

She spends a few moments checking to see whom Dr. Green operated upon last Friday. "Oh, thanks so much." "Sure, glad to help you."

Dr. Blank breezes in. "Say, that woman's name wasn't Johnson, after all. It was Jackson, Anne Jackson."

Well, that wasn't too hard to find, but it takes time.

The assistant is trying to code some of the diagnoses. "Can you index this?"

That is a puzzler. Miss Jones gets out her much-worn Nomenclature. She wants to help her assistant as much as possible because she is working toward registration. Then, too, the more she can code, the more help she will be in the department. This particular diagnosis takes more time than usual. It requires looking up in the medical dictionary (bless that book!) and of course the doctor has it spelled wrong. However, they finally find the proper code number, and they have both learned something new, even though it took precious minutes.

WANTS A BIRTH CERTIFICATE

"Br-r-r-n-ng!" Miss Jones groans. "I had a baby there in 1930. I never did receive a birth certificate." Miss Jones patiently explains that the certificates given by the hospital are of no legal significance anyway, and tells her where she should apply for one. "Yes, but my friend had a baby the same year, and she got one from the hospital. She showed it to me." "Maybe the hospital ran out of them at the time you had your baby, or something." "Well, I would sure like to have one. Will you find out for me if I can still get one?" "Yes—" (a deep sigh) "I'll find out. Call back sometime." Nine times out of 10 such people don't ever call back.

Hastily she inserts one of the insurance papers in the typewriter. A well dressed gentleman, carrying a brief case, enters. Smilingly, the gentleman asks to see the record of a patient. "I'm from the Homicide Insurance Company."

"Do you have the authorization?"

The gentleman smiles again. "Oh, come now. I don't have to have that just to see this record, do I?" He tries to wheedle her into a good humor, because her smile has disappeared. Miss

Jones is very sweet and friendly, and has a good reputation among the various callers at the hospital; but this she will not tolerate. "I'm sorry, I'm afraid you will."

He becomes a little impatient.

"Look—I go to any number of hospitals, and they don't require an authorization. I can get the information I want any time."

Miss Jones moves toward the telephone. "If you will give me the name of just one of those hospitals, I'll call and see what its policy is. Maybe there are new standards that I don't know about."

The man's face reddens. "Why—I'm sorry—I—I can't think of any right now."

Miss Jones' dimple shows again. "Of course you can't think of any at any time. Right?"

The man smiles again. "All right, you win. I'll get an authorization signed." He leaves the room smiling.

"I could sure stand a cup of coffee." This from her assistant.

"So could I. Shall we go down and get a cup?"

So they both deliberately leave the office for just a few moments, and hastily drink a cup of the stimulating beverage—and, of course, it is just the time of day when the administrator also feels the need of stimulant. He always sees them at those particular times, but he never sees the record room at its busiest, and wouldn't understand, if he did.

When they return, Dr. Fogey is waiting somewhat impatiently in the record room. He chews the big cigar abstractedly until he gets it into position, then puts his arm around Miss Jones. "Come on, honey, help me out a little."

"Oh dear, what do you want now?"

"Take this letter for me. I can't get anyone else to do it."

Miss Jones sighs. "If you only knew how much work we have—O.K., give it to me." The letter is fairly long, dealing with one of the patients in the house.

"It has to go out right away, otherwise I would use that thing"—pointing to the dictating machine. The insurance blank comes out of the typewriter, and Miss Jones types the letter for Dr. Fogey, very carefully, for he is one of those particular doctors. The medical record department sees every doctor at his very best and his very worst, and learns his reactions to very situation. So this letter must be very neat, and just as he dictated it.

Dr. Fogey returns later for the letter. He signs it himself, after he has read it over slowly, during which time Miss Jones holds her breath. It appears to satisfy him, so he takes it with him, and brings two "cokes" into the record room, for which she and her assistant thank him profusely, and then force them into their already full stomachs.

The insurance paper goes back into the typewriter.

A gentleman enters, asks for the "record clerk."

Miss Jones stifles the desire to say stiffly, "I'm the record *librarian*; why don't you lawyers and insurance companies get up to date?"

Instead, she asks "What can I do for you?"

He hands her a subpoena *duces tecum*, and she groans audibly. It is for tomorrow, first thing in the morning. She accepts the \$1.25, reflecting that it would in no wise pay for the lost hours the subpoena would cost her.

Her assistant leaves. Four o'clock already!

Dr. Smith enters rather hastily.

"Get me the old charts—all of them—on Mr. Ernest Frank, and bring them up to surgery, right away," he orders. He starts to leave, then he turns back, adding, "He's going to surgery as soon as we can get him up there, so hurry, won't you?"

Sighing, Miss Jones checks the patient's file. Just as she thought. Some of the man's charts were over in the "dungeon." There are about 10 of them altogether. The "dungeon" hasn't changed since this morning; it is still dark, and still dirty, and she sees a spider web across the tiny, dirty window that just barely lets in the late afternoon sunlight. She almost wishes something would happen to her over

in this old "dungeon," then maybe the hospital officials would do something about microfilming the charts, or something.

She finally gets all the charts together, and hurries up to surgery with them. "What took you so long?" asks Dr. Smith.

She bites her tongue to keep from saying anything, but lets him see her dirty hands and arms. She returns in a very bitter mood to the record room, and finishes one insurance paper.

All of a sudden, she remembers something. Tomorrow is the first of the month, and all the monthly reports have to be made. She lays her head on her typewriter and sighs. She looks at the stack of charts that doctors have completed in the last two days, which still must be indexed and filed. The box of cards that should be filed in the master file is still full. There are several records that are yet to be transcribed. She can think of dozens of things that should be done.

Five o'clock, and only one insurance paper has been completed. They *must* go out tomorrow!

The foregoing is light compared to some of the days. It is impossible to perform the many tasks necessary in the medical record department unless there is sufficient personnel. If there are not enough employees in that department, there are bound to be compromises somewhere. Either the charts will not be checked thoroughly, and therefore they will be filed when they should not be; or the indexes will not be entirely correct; or the filing will get far behind, with the result that a chart is not easily located when it is wanted. There is no room for compromise in the record department. Every phase of the work is important!

WRITE FOR YOUR VOLUME INDEX

If you bind your volumes of **The MODERN HOSPITAL** you will want the index to volume 74, covering issues from January through June 1950. You may obtain your free copy by writing to **The MODERN HOSPITAL** at 919 North Michigan Avenue, Chicago 11, Illinois.



CORRIDOR CUT-OFFS

provide flexibility in this hospital

WHEEL CHAIR romances" are not uncommon among long-term patients in institutions or hospitals designed for their care. Administrators of such institutions obviously are more concerned with the architectural planning, organization and administration of "coeducational" facilities, both recreational and therapeutic, than are administrators of hospitals for the acutely ill. The emphasis upon socio-recreational factors and the degree of fraternization among male and female patients is greater or less in proportion to the number of days' hospitalization and the degree of patients' ambulation.

The problem reaches its peak in hospitals for the treatment of mental illnesses. Here, separation by sex becomes necessary in living quarters as

LOUIS ALLEN ABRAMSON

Architect

J. J. GOLUB, M.D.

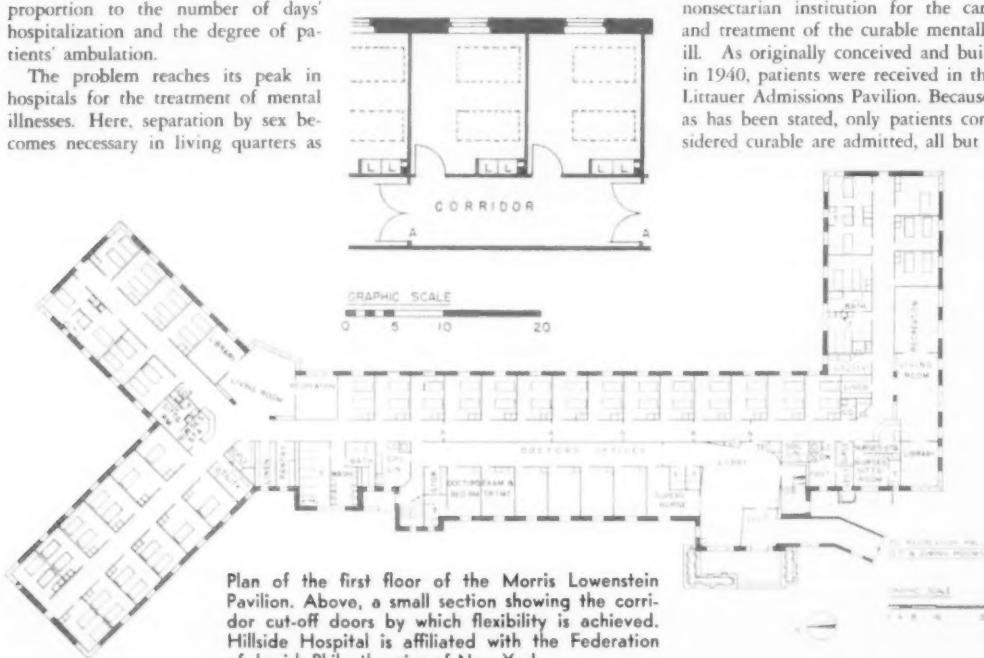
Hospital Consultant
New York City

a therapeutic measure rather than for moral or esthetic purposes. Sexual problems frequently underlie the very disturbances for which patients require admission to mental hospitals. Although schools of psychiatry differ, it

is generally conceded that sexuality, as a problem, is a potential among neurotic patients.

It follows then that separation by sex, especially upon admission and during the early period of observation and treatment, is essential. Further, added emotional disturbances and manifestations of hostilities by overt acts of aggression are best controlled by segregation by sex, particularly when patients are seriously disturbed.

Hillside Hospital, located in suburban New York City, is a nonprofit, nonsectarian institution for the care and treatment of the curable mentally ill. As originally conceived and built in 1940, patients were received in the Littauer Admissions Pavilion. Because, as has been stated, only patients considered curable are admitted, all but a



few of its approximately 100 patients may be considered ambulatory and are segregated as to both sex and degree of disturbance. Response to treatment is rewarded by transfer to one of the cottages which houses 21 patients. The patient is then allowed complete freedom of the unenclosed 53 acres of woods, fields, cultivated flower and truck gardens, and eventually is discharged.

In the planning of the existing group of buildings, much effort was made to predetermine the ratio between male and female bed capacities required for patients newly admitted and under observation. Statistical studies of admission applications by sex, made during the previous five years, demonstrated a marked fluctuation not only by year but by season. An average for the five-year period was

assumed and the type of accommodations in the existing admissions building was determined on this basis.

In the plans recently completed for additional structures, greater flexibility has been provided, thus eliminating the problem of vacancies in accommodations for one sex notwithstanding a waiting list in rooms assigned to the other.

Plans are now nearing completion for an expanded hospital which, when completed, will provide facilities for 200 patients and will include a new admissions building, additional cottages and combination auditorium and recreational hall seating 250.

To meet the challenging problem of providing maximum admissions and a minimum of vacancies, the new Lowenstein Pavilion incorporates in its plans an ingenious yet simple device,

i.e. the inclusion of corridor cut-off doors (see plan). Through the locking and unlocking of these barriers, the accommodations for either sex can be expanded or contracted in units of two or four beds. Thus, the male accommodations can vary from 21 to 53 beds, or a 40 per cent flexibility, while the female accommodations can vary within an even higher range, 50 to 82 beds, or 60 per cent. No other change is required inasmuch as exits and ancillary services have been designed for the maximum occupancies for each sex.

Through the proposed designs, the hospital can vary its admissions by sex and at all times maintain nearly a 100 per cent census. Flow of patients may be as free as in an active hospital private ward yet without sacrifice of discipline and control.

PATIENT IDENTIFICATION MADE POSITIVE

WHITELAW H. HUNT

Administrator
Cooper Hospital
Camden, N.J.

HOSPITAL administrators are loath to admit that mistakes occur that jeopardize the health of our patients. However, if we are honest with ourselves and, in the final analysis, honest with our patients, we not only admit that these mistakes do occur but make a sincere effort to prevent their recurrence.

It was only after several cases of mistaken identity had occurred at Cooper Hospital, Camden, N.J., within a relatively short time that we were able to take steps necessary to prevent them in the future. Fortunately, there were no serious results in the cases which focused our attention on the problem.

Like many hospitals we used bed cards to identify ward and semiprivate patients. These cards which were placed on the foot of each bed were frequently hidden from sight by the over-bed table or a carelessly placed blanket. (When placed on the head of the bed the cards are often hidden when the bed is elevated.)

One day Joe Bruno (so called for purpose of this article), a 65 year old native of Italy, who was in a semi-private room with Mike Caruso (also a fictitious name), about the same age and also a native of Italy, needed a blood transfusion. Joe was sound asleep when the laboratory technician

arrived to type him. She could not see the bed cards so asked Mike if he was Joe Bruno. He grunted some response which she interpreted as in the affirmative so she typed Mike. A short time later the technician took the blood up and asked the supervisor to assist her with the transfusion. When the technician went to Mike the supervisor told her no transfusion was ordered for him. The correct patient was found to be of a different type and Rh factor. A serious error was prevented by a narrow margin. This case made us stop and think. The following stirred us into action.

Baby A was admitted for surgery. Shortly before going to lunch one of the nurses bathed Baby A. While she was at lunch another nurse changed Baby A to another crib, then put Baby B in the crib. When the first nurse returned from lunch the operating room called for Baby A. She sent a student to the crib where she had left Baby A. The result is perfectly obvious, Baby B was being anesthetized when the nurse rushed to the operating room and told of the mistake.

After careful consideration of the combinations of events that made these two cases possible we decided the only

way to prevent the recurrence was to place an identification on the patient which would remain on him throughout his hospital stay.

We have chosen for this purpose a plastic bracelet, which is placed on the patient's right arm by the admitting officer. It is not removed until the patient is discharged and then only if the patient does not desire to keep it. Many of you will probably say, "The method is very good but it is too expensive." The bracelets are expensive, more so than other methods of identification, but we sell them to the patient at the actual cost and find that most patients are happy to have them.

The bracelet on the right arm is readily available for all to check for positive identification. All of our employees are instructed to check the bracelet before carrying out any order.

The bracelet has been used on approximately 5000 patients in the last four months and only three patients have asked to have the bracelets taken off before they were discharged. All were removed because they made the patients nervous and not because of any irritation.

We are well pleased with our method of positive identification. We feel that having recognized a problem we have successfully solved it.



Easton's experience with **POLIO**

*proves that a hospital can
be self-sufficient in an epidemic*

A. H. BRITTINGHAM

Administrator, Easton Hospital, Easton, Pa.

AFTER more than five months of strenuous effort, mental and physical fatigue beyond the average imagination—of ripping out cubicles, partitions, walls and building a quonset hut, we at Easton Hospital, Easton, Pa., are attempting to restore our staff and facilities to the normal function of a busy, overcrowded general hospital after handling the worst polio epidemic in the history of this area, one that claimed the lives of 11 of its victims, caused 113 patients to be admitted for hospital care, and undoubtedly visited thousands of others who suffered the mild symptoms that frequently are not recognized by the laity as the abortive type.

Our story actually begins a long time before the polio epidemic occurred—in early 1949 to be exact. In the spring of last year our local county polio committee, headed by Postmaster Henry Schultz, and consisting of representatives of the National Foundation for Infantile Paralysis, the public health staff, our medical staff, nursing and physical therapy departments, met to formulate detailed plans for handling any unusual number of

polio cases. Invited to this meeting were representatives from the Warren County, New Jersey, chapter of the foundation, since Easton Hospital also serves that county. Through the generosity of the Northampton County chapter of the national foundation, we had recently completed a modern physical therapy department (described in the April 1949 issue of *The MODERN HOSPITAL*) and also rejuvenated one of our ambulances which, among other equipment, carried a new portable resuscitator, so valuable in the bulbar type of polio.

Since our isolation unit contains only 10 beds, it was agreed that, should the need exist, we would reverse this unit with our 25 bed pediatric department, and all would be well! The meeting disbanded, and we all felt confident that the situation was well in hand.

On June 20 we received our first case, and practically one month later, on July 18, our second. By August 9 we had admitted six cases and were somewhat concerned, since that figure represented the total number of cases treated by the hospital during the previous year. Two days later, three new

cases were admitted; and now with our isolation unit filled, Dr. Rolf E. Johnson, our orthopedist, and I were seriously concerned.

That night I decided to strip our physical therapy department of all but the portable baths and Hubbard tank and to install eight beds. I also removed the cubicle partitions in our isolation unit to "squeeze in another case or two" if the emergency presented itself. Six days later, on August 15, all of the expanded space was occupied, and two resuscitators and four hot pack machines had been flown in by the national foundation. To me it appeared that our area was in for a full-blown epidemic and administrative problems were mounting daily in our attempt to stay one or two beds ahead of this catastrophe. The only available space left at this time was that occupied by our clinics. After a conference with the board of trustees and chiefs of services, I publicly announced through the radio and press that after August 17 clinics would be discontinued during the emergency. However, all patients requiring injections and certain medical and surgical ambulatory treatments would receive such care by special appointment. Our social service director capably managed this part of the program, and our nurses and staff physicians rendered such care in our emergency receiving ward.

In the meantime, our maintenance department was performing miracles day and night following my organized



Above: Families crowded around open windows near polio patients so it was necessary to shade the bottom section and open the top. **Left:** Map showing the area of the epidemic.

pattern of ripping out walls and partitions, and completing a new 10 bed unit in the clinic space, which was ready for occupancy in 72 hours.

In the interim, I met with our county commissioners, explained to them what was happening, and asked them for a contribution of \$3000 to equip this unit. It was unanimously approved immediately.

Meanwhile, seven new patients were admitted, so we quickly converted our employees' dining room into a six-bed unit and paid these employees cash to eat outside the hospital.

At that stage of the chaos, several conferences were called. One was with department heads to brief their employees on rigid rules and regulations which I expected to be enforced to the letter regarding personal cleanliness, isolating themselves from families or friends with children, persistent adherence to isolation techniques, special methods of handling food service and washing of dishes in temporary isolation areas, fly and garbage control, very restricted visiting throughout the entire hospital, and a multitude of other exacting and complex orders.

Next, was a meeting with the representatives of the national foundation; and this conference resulted in a simplified financial procedure that involved a minimum of bookkeeping. The national foundation assumed the responsibility for the cost of the entire epidemic at an agreed flat rate of \$13.50 per day to all patients. Letters were mailed by us to the patient or legal guardian, outlining this entire program and advising that all contributions be paid direct to the local chapter of the national foundation. Those covered in whole or part by Blue Cross or other forms of insurance were so credited by us to the national foundation. It was further agreed that all polio patients admitted would retain their family physician, but our orthopedist would be consultant on all cases without exception and without cost to the family, this fee to be included in the national foundation's program of underwriting the epidemic.

The final conference was with the board of trustees. I expressed the opinion that it was apparent the time had come either to turn additional

cases away or to provide added temporary facilities. I recommended the latter for the following reasons:

1. We were morally obligated to accept cases from Northampton and Bucks counties in Pennsylvania, and Sussex, Warren and Hunterdon counties in New Jersey.

2. It might be fatal to transport a bulbar type of patient to some hospital many miles beyond us.

3. Confidence, hope and spiritual guidance played an important part in each patient's chance of recovery. The opportunity to have his own physician, his own parents, his own pastor near him all the time should not be denied him.

Approval was given and the public was informed by the press and radio which were "in" on all of these conferences. The response was magnificent and inconceivable. We asked the public to donate \$20,000, but in a few days that amount was pledged and we announced reaching our goal and thanked the public. The community refused to stop giving, and the total finally reached \$45,977.37. Radio Station WEST undertook its own campaign to raise the entire cost and did—with contributions of \$21,608.04. It was, without a doubt, the most amazing example of complete community sympathetic understanding.

The next seven days were a nightmare; but by pressure, pleading, demanding beyond reason and expecting the impossible, a completely equipped Quonset hut was completed and occupied in seven days.

Our hut is far more complicated than you might imagine in comparison with the war-time structure. It is 20 feet by 60 feet on a concrete block foundation, with double floors and insulation for all-weather protection. It includes curtain cubicles, special beds and complete utility units, toilet facilities, built-in sterilizer, special heating and lighting, refrigeration, drug cab-



nets, nurses' station, portable ice chest, linen hampers, electric food carts—a complete medical unit. Such emergency units are expensive. For instance, the sterilizer cost \$386, the special food carts, \$1000, drug cabinet, \$369; plumbing installation was a contribution valued at more than \$3000—just to name a few.

Our procedures were simplified as far as possible without breaking technique. Patients were admitted to our "spinal tap room" located near the entrance to the receiving ward and were discharged from there or assigned to a bed in one of the polio units. Admitting procedures followed the usual methods relative to notifying the various departments, except that the business office followed a simplified procedure and no charge slips were recorded. It must be remembered that this system was not inaugurated until two weeks after the epidemic was in full force. We carefully tabulated costs during those first two weeks, and from this experience arrived at the per diem flat rate.

Heated food carts were conveyed to the door of each unit and the trays were handed in, so that the cart would



Above: One of the polio victims receiving treatment in the Quonset hut, which was set up and completely equipped in seven days. Right: Treatment is given in the Hubbard tank.

not be contaminated. Dishes, cups and so forth were paper, and after the meal a truck was brought to the unit to pick up the paper containers and convey them directly to our incinerator. Trays and silver were sterilized in our isolation unit kitchen and then returned to the main kitchen.

The national foundation assumed full responsibility for keeping us supplied with respirators and hot pack machines—at times a momentous job, since we used as many as six respirators and 26 hot pack machines simultaneously. At peak load, our polio unit teams were giving as many as 1800 hot packs a day.

Nursing did not represent a problem, and here, again, we used an efficient system. Those nurses not having young children of their own or living where young children also resided

were accepted for duty and their places on the staff were temporarily filled by private duty nurses or members of our nurses' alumnae association.

All nurses on duty in the polio unit were granted a temporary increase of 35 per cent. We also added two physical therapists to our staff, making a total of four. Through the press and radio we appealed for helping hands to apply hot packs and assist in serving meals. Forty volunteers responded, some of them parents of the patients themselves. No one was supposed to work more than eight hours, and we honestly attempted to be strict about this ruling.

Of our total personnel, two nurses were stricken with polio, one fatally. One of these nurses was in Canada on her vacation and was admitted on

her return. The other nurse was at no time near the polio unit; she served in the maternity ward.

Eventually, came the problem of ambulatory care. This was solved by carefully working out a schedule revised each week and using our station wagon to convey the patients on a schedule coordinated with the physical therapy department. The epidemic ended about October 15, although sporadic cases have continued to be admitted. On October 16 our clinics were restored and the dining room returned to its normal function. By October 31 our isolation unit was again opened for the admission of communicable diseases and our polio census reduced to 20, one of whom remained in a respirator.

We intend to use our hut temporarily for a meeting room, but will hold it in reserve for emergency facilities if needed. When our new addition to the hospital is completed, it will make an excellent repair shop for the maintenance department. The surplus funds will be used to add a department of occupational therapy in our new hospital.

Some interesting statistics emerged from our experience:

1. The use of the social worker's techniques in having the patient accept his diagnosis.

2. The social worker's explanation of sanatorium routine and, very often, a transfer of dependency of the patient from the family to the social worker. This is the period in which the patient is helped to adjust to sanatorium life.

3. The social worker's aid to the patient's family in helping it to adjust to a new situation.

4. The social worker's rôle in planning for the patient's discharge and eventual reintegration into the family and community life. This is an important aspect of the social worker's activities inasmuch as many patients, contrary to popular belief, are not eager to leave the sanatorium. Rather, through their long stay in the institution, they have become dependent on it and often subconsciously resist planning for discharge.

The authors describe an interesting case illustrating the rôle of the case worker in the total treatment of the patient from diagnosis through discharge and rehabilitation.—I. GOTTSCHEN, assistant director, Montefiore Hospital Country Sanatorium, Bedford Hills, N.Y.

The Place of the Social Worker

in a Tuberculosis Hospital

A N INTERESTING paper on "The Place of the Social Worker in a Tuberculosis Hospital," which appears in the February 1950 issue of *Diseases of the Chest*, by Allan Hurst, M.D., Harold Nitzberg and Martia Hempel reports that the medical profession is growing more aware of the importance of social work as an aid to the treatment of tuberculous patients. The fact that social work has evolved into an established profession with high standards makes it more useful as an ancillary service for the physician.

The authors state that in order to develop a true psycho-social approach to this illness, especially since it is long term, it is necessary to place more trust in the social worker. They state that social case work concerns itself with the social and emotional problems arising out of the patient's illness. The case work method must be used from the establishment of the patient's diagnosis through hospital care and after care. The basic tool of this method is the establishment of rapport between the patient and the social worker through the technic of interviewing. Through the patient as a focus, the social worker acts for the patient, the sanatorium and the community.

The authors discuss each stage of

the patient's illness and his relationship to the social worker as follows:

1. The use of the social worker's techniques in having the patient accept his diagnosis.
2. The social worker's explanation of sanatorium routine and, very often, a transfer of dependency of the patient from the family to the social worker. This is the period in which the patient is helped to adjust to sanatorium life.
3. The social worker's aid to the patient's family in helping it to adjust to a new situation.
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The authors describe an interesting case illustrating the rôle of the case worker in the total treatment of the patient from diagnosis through discharge and rehabilitation.—I. GOTTSCHEN, assistant director, Montefiore Hospital Country Sanatorium, Bedford Hills, N.Y.

THESE TESTS HELP THE HOSPITAL TO

Measure Nursing Quality

MARGARET K. SCHAFER

Senior Nurse Officer
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Hospital Resources
U.S. Public Health Service

ONLY we know whether the patient receives the care he should get, but only the patient knows whether he is getting the care he thinks he should get." Dr. Paul R. Hawley, director of the American College of Surgeons, made this statement when he was chief surgeon of the European Theater of Operations during World War II.

PATIENT'S MEASURE OF GOOD CARE

What factors do patients consider in measuring their nursing care? A patient feels he is getting good care when:

1. He receives courteous, gentle, considerate care.
2. He believes that the nurses and other hospital personnel are interested in him as an individual and not just another patient.
3. His friends, relatives and belongings receive careful, thoughtful, considerate care.
4. He has a feeling of security because the hospital staff is interested in his recovery, comfort, health, happiness and general well-being.
5. He is kept clean and comfortable.
6. His treatments and medications are administered skillfully, thoughtfully, considerately and on time.
7. His nourishment—food and drink—is adequate, tasty, attractively served, on time and when he desires it.
8. He has confidence in the skill and ability of the workers.
9. He is aware of a feeling of happiness and job satisfaction among the workers, with no feeling of unrest.
10. His environment is kept clean and attractive and the general sanitation and orderliness of the hospital are good.

What factors do we consider in measuring nursing care? We say our patients are receiving good care when:

1. The primary consideration of the nursing staff is a humanitarian attitude toward its patients.
2. The hospital buildings are free from hazards, and properly equipped

to permit comfort and scientific care to patients.

3. The nursing department organization displays the fundamental principles of good management.

4. The nursing department is composed of a sufficient number of nurses with the necessary qualifications to provide safe, adequate nursing care to all patients.

5. The nursing personnel performance satisfies the physical, mental, emotional and health teaching needs of all patients.

Let us first consider the humanitarian attitude of the nursing staff toward the patients. Might we enlarge the scope of this statement to include the feeling of service to the community? Then we can think of the hospital in the broader sphere to include preventive as well as curative aspects of medical care and to extend beyond the "walls."

STRESS HUMANITARIAN ATTITUDE

All members of the health team, and especially our nursing personnel, must possess and display by their attitudes and treatment of patients a sincere interest in their health and well-being. When a hospital lacks the "milk of human kindness" it lacks its real purpose for existing. When I visit a hospital one of the questions I always ask myself is, "Would I want to be a patient in this hospital?" The humanitarian attitude of the nurses and other personnel strongly influences my answer.

A hospital should be free from hazards and should be properly equipped for the comfort and scientific care of the sick. All of us can give examples of excellent nursing care in an outmoded, inconvenient building with meager supplies and equipment, but give the same staff and the same good

organization a convenient building with good supplies and equipment and the nursing care should be better. When nurses must travel long distances between patients, when suitable supplies and equipment are lacking, when makeshifts have to be devised because there are not enough sheets, hot water bottles, medicine glasses and sterile dressings the nursing care can be neither efficient nor economical. When ambulant patients, weak and debilitated, must walk great distances to showers and toilets accidents may occur.

ORGANIZATION INFLUENCES CARE

The nursing department organization must display the fundamental principles of good management. Much has been said about good management and how it affects good hospital operation. The organizational pattern of the whole hospital, as well as the organization of the nursing department, influences the hospital's nursing care. When the organization of the nursing department is clearly defined, the nurses are qualified, oriented and organized so they understand their functions, and if they are carefully and democratically supervised, the patients receive good nursing care.

The nursing department must be staffed with a sufficient number of nurses with the necessary qualifications to provide safe adequate nursing care to all patients. It is generally known that a large number of workers in an organization does not necessarily guarantee a high quality of performance, but it is generally agreed that when an insufficient number of workers is provided to perform the necessary tasks, some functions must of necessity be omitted or short cuts must be taken.

In determining the number and qualifications of the nursing personnel required in a hospital, all areas of the nursing service are studied, i.e. administration and supervision, general bedside nursing care, and nursing services

in all areas, including the operating room, delivery room, outpatient department, and nonpatient nursing service areas, such as the central supply room, which are essential to good nursing care.

Standards based on studies made in hospitals where the nursing care is considered "good" are used as criteria in determining the adequacy of a hospital's nursing staff, but each hospital must study and measure the adequacy of its staff in the light of its own needs.

How many nurses are required to plan, organize and supervise a hospital nursing service? First, we will want to know what hospital functions are included in the nursing service. Are housekeeping, dietary and nonnursing administrative and clerical functions allocated to their respective departments, or are nurse supervisors preparing pay rolls, directing housekeeping personnel, and supervising the preparation and serving of food? Do the directors of nurses, the supervisors and head nurses understand the principles of good management, organization and supervision and do they put these principles into practice? The usual criterion used to determine the number of administrative-supervisory nurse personnel required is the ratio of patients to nurse supervisor. Should the number, qualifications and training of the nurses and other employees under her jurisdiction be other criteria? It has been demonstrated that a nursing staff comprised of a large proportion of nonprofessional nurses requires careful organization, orientation, training, assignment and supervision.

PATTERNS ARE DIVERSIFIED

The diversified patterns of nursing organization in different hospitals and often within a single hospital make it difficult to compare nurse supervisory requirements. For example, hospital A has a head nurse assigned to each nursing unit, including the operating room, outpatient unit, and central supply room, and these head nurses are directly responsible to the director of nurses. Hospital B has a head nurse for each unit and supervisors in various areas of the hospital, such as medical, surgical and obstetrical, who in turn have organization lines to the director. There are other variations of these patterns.

Realizing the limitations of any criteria based only on existing practices I should like to consider, in the absence of much-needed research, the

criteria suggested for administrative nursing personnel in the manual, "Measuring Nursing Resources."¹

Type of Administrative Nursing Personnel	Daily Average Census Including Newborn
1 Day Supervisor.....	57 patients
1 Evening Supervisor.....	57 patients
1 Night Supervisor.....	80 patients
1 Head Nurse.....	19 patients

A recent study of 22 select general hospitals of less than 100 beds showed: one administrator-supervisor-head nurse to 18 patients (including newborn infants)² and one head nurse to 31 patients.³

SAVES HEAD NURSE'S TIME

It has been demonstrated that the assignment of a ward clerk or ward secretary relieves the head nurse of many routine clerical functions and increases the time available for supervision. It should therefore increase the efficiency of the nursing unit. A study in one of the hospitals in Washington, D.C., of the proportion of head nurse and professional bedside nurse time spent performing clerical activities on a nursing unit with and without a ward clerk is worthy of note. It showed that the head nurse spent 37.8 per cent of her time performing clerical duties when no ward clerk was available and only 3.1 per cent when a ward clerk was employed. The ward clerk reduced the clerical functions of the bedside professional nurse from 6 per cent to 0.9 per cent.

The amount of bedside nursing care is usually determined by the average number of hours of care available per patient in 24 hours.

When determining the adequacy of the average number of hours of nursing care provided per patient we consider:

1. The plan and arrangement of the building and the facilities within the building. When nurses must walk long distances between patients or to obtain supplies and equipment there is less time for nursing care.

2. The kind, amount and distribution of supplies and equipment; assembled sets, sterile and ready for use, prepared by a central supply room, leave more nursing time for patient care.

¹ Federal Security Agency, Public Health Service, Division of Medical and Hospital Resources and Division of Nursing Resources, Washington, D.C., 1949.

² Includes nurses assigned to director of nurses' office, supervisors and head nurses.

³ Federal Security Agency, Public Health Service, Division of Medical and Hospital Resources; Staffing Small General Hospitals, A Study of Staffing in General Hospitals (less than 100 beds).

3. Diagnosis and degree of illness.
4. The kind and amount of care given the patients.

5. The number and types of surgical operations.

6. The schedule for surgical operations, dressings, treatments and so on.

7. The kinds and numbers of emergencies and accidents.

8. The qualifications, education, training and organization of the nursing personnel.

9. The prevailing medical practice, including research, kinds of treatments, medications, services rendered, and the medical practices of the hospital.

STATUS OF ILLNESS CHANGES

A study conducted at the University of California Hospital revealed that the use of antibiotics and early ambulation of surgical patients has resulted in a constant change in the status of patients' illnesses as indicated by the number of orders written by the doctor. Where several years ago one set of postoperative orders remained practically unchanged until a patient was discharged, now the patient progresses from bed rest to some ambulation and then to ambulant status. This change in status causes a continual change of physiology and a resultant need for changes in treatment and care. Patients permitted early ambulation following surgery require considerable nursing time for reassurance and mental preparation for the increased activity. They require assistance in and out of bed several times a day and support while walking for at least a few times. Maids can make empty beds, but it requires skillful nursing by qualified nurses to carry out complicated procedures and to care properly for patients.⁴

The hours of nursing care per patient and the proportion of this care to be performed by professional and nonprofessional nursing personnel require careful study in every hospital and every unit within the hospital. Two of the guides available are: "A Study of the Nursing Service in One Children's and Twenty-One General Hospitals"⁵ and "Staffing the General Hospital: 25 to 100 Beds."⁶

⁴ Binehamer, H., Loveland, D., and Ellis, R.: Our Patients Require More Care, a study of charges occurring in the care of patients under present methods of treatment, Am. J. Nursing 48:366 (June) 1948.

⁵ National League of Nursing Education, Department of Studies, New York, 1948.

⁶ Federal Security Agency, Public Health Service, Division of Medical and Hospital Resources, Washington, D.C., 1949.

"A Study of Nursing Service in One Children's and Twenty-One General Hospitals" recommends certain guides to the average number of general nursing hours needed per patient in 24 hours and the proportion of this care to be given by professional nurses.

tion of bedside care which should be given by the professional nurse on the dayshift (7 a.m. to 3 p.m.) to provide adequate, safe, economical nursing care on an active medical-surgical ward. In this study the team method of assignment was used providing a constant

tient care. Three elements are involved in the assignment of the nurse's aide or practical nurse:

1. The way in which the nurse's aide or practical nurse functions.
2. The duties of the nurse's aide or practical nurse.
3. The selection of patients to whom the nurse's aide or practical nurse may give varying proportions of care, dependent upon the patient: (a) degree of illness, (b) control of activity, (c) behavior reaction, (d) application of theory, (e) teaching and rehabilitation.⁷

MEASUREMENT IS NOT EASY

Measuring the performance of nursing to determine whether it is satisfying the physical, mental, emotional and health teaching needs of our patients is not easy because of the many subjective factors that enter into our judgments, but studies to measure objectively the effects of nursing care reveal interesting results. One such study was carried on by a nurse in a large army hospital on a 75 bed plastic surgery ward with approximately 50 per cent of the beds occupied by recent postoperative patients. The aim was to determine whether "extra" nursing care would reduce the need for sedation. Findings showed that

1. On evenings when an extra hour was taken in preparing patients for bed by giving longer back rubs, refilling water pitchers the second time if necessary, and the old iron clad rule of "lights out" was overlooked to allow the nurse extra time with the patients (60 minutes divided among 75 patients is not much), the amount of sedation was reduced 33 per cent.

2. On evenings when, in addition to the extra nursing care, the doctor visited the patients at bed time, the sedation was reduced another 12 per cent (45 per cent total).⁸

In conclusion, if the nursing performance is such that the principles of good medical and surgical aseptic technic are practiced, the patients are clean and comfortable, their treatments and medications are administered skillfully, thoughtfully and on time, and their physical, emotional and health teaching needs are fulfilled, we can honestly say our patients are receiving good nursing care.

Service	Average Number Hours' Care per Patient in 24 Hours	Proportion of Hours' Care by Professional Nurses
Medical.....	3.4	65%
Surgical.....	3.5	70%
Mixed (medical and surgical).....	3.4	67%
Obstetric		
Postpartum mothers.....	3.0	65%
Newborn infants.....	2.8	77%
Delivery and labor room.....	(1.2 per postpartum mother)	
Pediatric—all ages.....	4.6	80%
In private accommodations (medical and surgical).....	3.8	70%

The average number of patients, exclusive of newborn infants, in the hospitals studied for this report, varied from 149 to 753 patients. Twenty of the hospitals were associated with professional schools of nursing. Two of the hospitals operated schools for trained practical nurses.

The average hours of nursing care per patient, including the newborn infant, in 24 hours and the proportion of care recommended for professional nurses in "Staffing the General Hospital—25 to 100 Beds," are:

Size of Hospital	Average Number of Hours per Patient in 24 Hours	Proportion of Hours of Care by Professional Nurses
25 Bed.....	4.6	58%
50 Bed.....	3.7	52%
75 Bed.....	3.6	52%
100 Bed.....	3.4	51%

This guide was based on the statistical analysis of the staffing in 22 general hospitals with from 22 to 88 beds but without schools of nursing. The small hospital requires a proportionately larger number of personnel and a larger proportion of professional care to ensure adequate coverage at all times of the day.

An interesting and valuable study in one of the large general hospitals in Washington, D.C., has been made by a student in the department of nursing education at the Catholic University of America. It deals with the propor-

to perform bedside nursing care of patients whose condition required her attention. This hospital conducts a well organized in-service training program for nurse's aides and has been using the team method of assignment for approximately one year.

The assignment of duties to various members of the nursing team requires careful study, consideration and supervision. First, as many nursing service functions as possible are assigned to a housekeeping maid or nurse's aide and then nurse's aides or practical nurses are utilized to assist with pa-

⁷ Criteria for the Assignment of the Nursing Aide, Am. J. Nursing 49:311 (May) 1949.

⁸ Schwartz, D.: "Nursing Care Can Be Measured," Am. J. Nursing 48:149 (March) 1948.

Punch Card Accounting

lightens the load of paper work

FRANK R. BRADLEY, M.D., and WILLIAM ANDERSON
Respectively, Director and Comptroller, Barnes Hospital, St. Louis

THE most radical change in our transfer from conventional accounting to punch card accounting was encountered during the development of the application covering patients' accounts receivable. Heretofore it was believed that the punch card equipment was not entirely suitable or adaptable to this particular phase of the work. However, after considerable research, investigation and planning, the patients' accounts receivable were transferred to punch cards. At this hospital the task was a tremendous one inasmuch as more than 6000 accounts were involved in the changeover.

Many times during the development period, obstacles arose which seemed insurmountable. However, after many trials, all these problems were solved.

The application as it now stands produces, in addition to the patient's account, many reports which were unobtainable previously. The procedure was further involved by the fact that three hospitals had to be considered in this application through the centralized tabulating department. Many applications were developed which were thought impractical at the commencement of this work and which later proved to be of outstanding value. One such procedure was the automatic segregation of group hospital (Blue Cross) patients' charges and credits that apply to the patient's portion of the account from charges which are allowed under the Group Hospital contract.

A sample of this work is shown in figure 1 at right.

The eight cards used in this application are as follows:

This is the second article in a series by Dr. Bradley and Mr. Anderson on the machine accounting procedure in use at Barnes Hospital, St. Louis. Successive articles on this procedure will appear in forthcoming issues of this magazine.

1. Address and personal data card—subdivided into three sections: (a) patient's name and address, (b) admitting data, (c) account guarantor's name and address.
2. Financial and statistical card—lower portion of card No. 1.
3. Charge card—debit transaction card.
4. Credit card—credit transaction card.
5. Cash receipt card.
6. Patient's account balance forward card.
7. Aged trial balance forward card—standard blank cards.

8. Class name card or "type of transaction" card—standard blank card.

From the cards enumerated, all transactions relating to patients' accounts receivable are handled, and the following reports and records are produced therefrom:

1. Daily posting list of charges and credits affecting individual accounts.
2. Patients' statements.
3. Cash receipts register.
4. Bank deposit ticket.
5. Sales journal—classified by type of sales.
6. Cash journal—which is the general cash receipts journal.

STATEMENT BARNES HOSPITAL 600 E. KINGSHIGHWAY ST. LOUIS 10, MO.					
				REGISTRATION NO. 12150 105000364	
PLEASE DETACH AND RETURN THIS STUB WITH REMITTANCE					
DATE NO. PAY	EXPLANATION	GROUP HOSPITAL FEE	DEBITS	CREDITS	BALANCE PAY LAST AMOUNT IN THIS COLUMN
	BALANCE FORWARD		950		
112 ROOM BOARD		450			
112 G H ROOM BD		1500			
112 ROUTINE LAB			950		
113 ROOM BOARD		450			
113 G H ROOM BD		450			
113 UNAPPR DRUGS			1500		
113 DRUGS		600			
113 DRUGS		180			
114 ROOM BOARD		450	950		
114 G H ROOM BD		450			
115 ROOM BOARD		450	950		
115 G H ROOM BD		450			
116 ROOM BOARD		450	950		
116 G H ROOM BD		450			
117 DRUGS		600			
117 DRUGS		180			
118 ROOM BOARD		450	950		
118 G H ROOM BD		450			
119 ROOM BOARD		450	950		
119 G H ROOM BD		450			
120 DRUGS		100			
120 DRUGS		100			
119 ROOM BOARD			950		
119 G H ROOM BD		450			
119 X RAY		*	2000		
120 CASH				5680	
			6580		5420
NO PROFESSIONAL FEES ARE INCLUDED IN THIS SERVICE					
CHARGE OF \$1.00 WILL BE MADE FOR DUPLICATE COPY OF THIS STATEMENT					
TERMS OF PAYMENT: ROOM CHARGE WEEKLY IN ADVANCE					
EXTRAS AS STATEMENT IS RENDERED					
BARNES HOSPITAL			ST. LOUIS, MISSOURI		

FIG. I.—SEGREGATION OF GROUP HOSPITAL CHARGES AND CREDITS.

The figure displays four types of cards used in hospital accounting:

- Patient Information Card:** This large card contains fields for Registration Number, Patient's Name, Address, City-State, Attending Physician, Religion, Room No., Bed No., Room Rate, Admit Date, and Discharge Date.
- Guarantor Card:** This smaller card contains fields for Registration Number, Name of Guarantor, Address, City-State, and Room Number.
- Debit Transaction Card:** This card is divided into three sections: Class Name, Entry Date, and Date Charged. It also includes fields for Registration Number, Account No., Income Class, and Amount.
- Credit Transaction Card:** Similar to the debit card, it has sections for Class Name, Entry Date, and Date Paid, along with fields for Registration Number, Account No., Income Class, and Amount.

FIG. 2—SAMPLES OF CARDS USED.

7. Accounts receivable aged trial balance.

8. Trial balance of bad accounts and attorney accounts. These reports will be discussed later in this series of articles.

Figure 2 (above) shows samples of the cards used in this application. Following is a brief description of their design and purpose.

The address and personal data card, which is divided into three sections, is designed for the purpose of heading the patient's ledger account and statement, from information obtained from the admitting record. The patient's name and address portion of the card is divided into four fields:

1. Hospital registration number.
2. Name of patient.
3. Street address.
4. City and state address.

The admitting data portion of the card is divided into five fields as follows:

1. Hospital registration number.
2. Room number.
3. Room rate.
4. Admitting date.
5. Time admitted.

The guarantor portion of the card is divided into four fields as follows:

1. Hospital registration number.

2. Name of guarantor.

3. Street address of guarantor.

4. City and state address of guarantor.

The three parts of this particular card produce the entire heading for the patient's ledger and statement.

The financial and statistical card was designed to compile admitting statistics on patients by type of hospital service, such as general medicine and general surgery, and, further, to show the type of accommodation obtained, i.e. private, semiprivate, ward. This card is divided into 20 fields as follows:

1. Hospital registration number.
2. Name of patient.
3. City address.
4. State address.
5. Age.
6. Sex.
7. Race.
8. Attending physician.
9. Type of hospital service.
10. How referred to hospital.
11. Religion.
12. Room number.
13. Nursing division.
14. Accommodation code—private, semiprivate, ward.
15. Room rate.
16. Admitting date.
17. Type of insurance.
18. For group hospital insurance, whether dependent or subscriber.
19. Discharge date.
20. Amount of total hospital bill.

Several of the fields noted are coded further to provide complete analysis of the admission. For example, Field No. 17, "Type of Insurance," is subdivided into five classifications and, in addition, many sub-reports can be tabulated from several of the codes included in this card.

The charge card or debit transaction card is used to designate the class and amount of debit posting to the patient's account, such as room and board charge, operating room charge, anesthetic charge. This card is divided into 11 fields containing the following information:

1. Hospital registration number.
2. Hospital number (refers to one of the three hospitals in the group).
3. Account number — income account number.
4. Nursing division.
5. Class number—type of charge, i.e. drugs.
6. Class name—name of charge, i.e. drugs.
7. Entry date — entry posting date — date charge is posted on ledger.

BARNES HOSPITAL

500 SOUTH KINGSHIGHWAY
ST. LOUIS 10, MO.
PATIENT'S LEDGER

HOSPITAL CO.

REGISTRATION NO.				PATIENT'S LEDGER				
105000364				SMITH A GRACE 6837 KINGSHIGHWAY ST LOUIS MO				
DATE	ROOM	RATE	TIME	1117	1400	01120GS11	25A	
				MR	WALTER B SMITH			
				6837	KINGSHIGHWAY			
	DISCHARGED			ST	LOUIS MO			

FIG. 3—DATA TRANSFERRED TO PATIENT'S LEDGER ACCOUNT

8. Entry code — type of transaction

9. Date charged — date charge was made

10. Amount of charge

11. Group hospital indication

11. Group hospital ledger.

It should be stated here that the patient's ledger is compiled from the daily posting list of charges and credits affecting the individual accounts by a duplicating process known as transfer posting. No alphabetical description is shown on this ledger, all transactions being denoted numerically, including the information previously described in connection with the charge card. However, a code is shown on this ledger describing each class of entry made. The ledger is designed in duplicate form, one of which is the patient's copy and the other the hospital copy.

The credit card in connection with this application is used for all credit transactions with the exception of credit for cash payment. Adjustments for allowances, discounts and charity are posted with the use of this card.

The fields in the credit card are identical with those listed for the charge card, with the one exception of entry code.

The *cash receipt card* is a transcription of the cashier's receipt prepared at the time payment is received, the purpose of which is to record on the patient's ledger cash payments made to the account. The card is divided into 13 fields as follows:

1. Hospital registration number.
2. Hospital number—refers to one of the three hospitals in the group.
3. Cash account number.
4. Class number—type of transaction.
5. Class name—class of payment.
6. Entry date—date of posting.
7. Entry code.
8. Date paid—date of payment.
9. Amount of payment.
10. Group hospital — indicates source of payment.
11. Receipt number.
12. Transit number — bank clearing house designation.
13. Check or cash.

13. Check or cash.
The patient's balance forward card is obtained automatically by the summary punching method from the reproducer as the transactions, both charge and credit, are accumulated by the tabulator. This card indicates the amount the patient owes at the date of the last posting. The use of the

card is to carry forward the amount owed by the patient, to which are added or subtracted the transactions of the following day. This procedure also applies to the group hospital portion of the patient's account, as separate and distinct balances are maintained for each of the two debtors.

The patient's balance forward card is divided into five fields as follows:

1. Hospital registration number.
2. Entry date—date card was summary punched.
3. Entry code—current, installment, bad debt account, or attorney account
4. Patient's account balance forward amount.
5. Group hospitalization insurance balance forward amount.

The *aged trial balance forward card* is used in the preparation of the accounts receivable aged trial balance report. This card is reproduced from the patient's balance forward card and contains the following information:

1. Hospital registration number.
2. Patient's account balance forward amount.
3. Entry code—transaction code.
4. Group hospital balance forward amount.
5. Aging of the account—whether the account is 30 days old, 60 days, 90 days, and so on.

This particular procedure actually produces the trial balance of outstanding accounts receivable in proof of the general ledger control account and simultaneously furnishes an analysis of each account as to age. This subject is discussed further in a later paragraph.

The class *name card*, designated as "type of transaction" card, shows the type of transaction, such as room and board, drugs and so on, and is used to enter the account name with respect to the patient's statement and the account number with respect to cash and sales journal. The data for this card

Registration Number	Date	Group Hospital Pays	Charges	Credit	Balance Forward	Registration Number	Date	Group Hospital Pays	Charges	Credit	Balance Forward
105000363	1130 1		1000			105000363	1130 1	*	1000		*
105000363	113051			2000		105000363	113051			2000	
					1000CR			*			1000CR*
105000364	1120	1950			950	105000364	1120	1950			950
105000364	1130 1		950			105000364	1130 1			950	
105000364	1130 1	450				105000364	1130 1	450			
105000364	113065		1500			105000364	113065			1500	
105000364	113011	600				105000364	113011	600			
105000364	113011	180				105000364	113011	180			
		3180			3400			3180	*		3400 *

FIG. 4—PATIENT'S LEDGER COMPLETED FOR THE SAMPLE ACCOUNT.

are obtained from the chart of accounts for income and source of cash classification. This card contains the following fields:

1. Hospital number — refers to one of the three hospitals in the group.
2. Account number — income or cash classification of accounts.
3. Class number — type of charge.
4. Class name — name of charge, such as drugs — with respect to patient's statement.

All major cards and transactions pertaining to this application have been described briefly. The next step in this procedure is the preparation of the patients' accounts receivable daily posting run, referred to previously as the transfer posting run of all transactions affecting each patient's account during the day, both charge and credit. The transactions are arranged by a sorting process in patient account order, which, in this instance, is by registration number indicated on the patient's ledger. Therefore, the listing of daily transactions is prepared for each individual account by registration number in one continuous run. The balance forward, as well as the closing balance, is shown on this listing which is prepared on the tabulating machine. Inasmuch as all calcula-

tions are done with the punch card equipment, the cashier is presented with a prebalanced work sheet covering the day's business. These transactions are posted each morning with the transfer posting machine directly to the patient's ledger, from the prebalanced listing.

The following information is transferred to the patient's account, from this listing:

1. Hospital registration number.
2. Date of posting.
3. Class number—type of transaction in accordance with code shown on ledger.
4. Group hospital amount.
5. Patient's charges.
6. Patient's credits and cash receipts.
7. Patient's balance.

This information is shown in figure 3.

Punch cards participating in this particular portion of the application are:

1. Patient's balance forward card.
2. Charge card.
3. Credit card.
4. Cash receipt card.

Figure 4 shows the patient's ledger as it appears when completed for the sample account.

Thus far we have explained the use of the various cards in this application in the preparation of the patient's ledger, the sales journal and the cash journal. We are now concerned with the preparation of the patient's statement of account. This statement, a sample of which was presented earlier in the chapter, is prepared weekly in accordance with our customary credit terms.

The principal distinction between the patient's ledger account and the patient's statement is that the patient's ledger, as we stated previously, is a transfer posting application, whereas the patient's statement is prepared entirely independently of the ledger itself, and from the cards previously used to accumulate the data that were originally posted to the patient's ledger account.

Another distinction between the patient's ledger account and the patient's statement is the alphabetical indication of charge and credit transactions on the statement instead of use of class code as on the patient's ledger. In other respects, the two statements are similar.

Cards used in the preparation of this statement are as follows:

1. Address and personal data card.

BARNES HOSPITAL									
ACCOUNTS RECEIVABLE AGED TRIAL BALANCE									
REGISTRATION NUMBER	CHARITY #	PRIOR #	BEGINNING #	60 DAYS #	30 DAYS #	CURRENT	DATE	BAD DEBT #	ATTORNEY #
1050000221		12394					12394		
1050000232		80110					29210		
1050000245		6000					5000		
1050000246		3380					3380		
1050000253		17277					17277		
1050000254		12216					12216		
1050000256		24480					24480		
1050000264		5000					5000		
1050000275		6000					6000		
1050000284		18418					18418		
1050000296		4129					4129		
1050000300		50					50		
1050000302			15902				15902		
1050000312			11261				11261		
1050000315			107526				107526		
1050000329			7250				7250		
1050000332			6674				6674		
1050000340				12000			12000		
1050000364				5420			5420		
1050000371				57458			57458		
1050000380				29157			29157		
1050000381				1380			1380		
1050000389				3000			3000		
		50884	58973	28597	148633	108415	395502		
105000044							12968		32968
105000055							1000		1000
105000066							45743		45743
105000085							12310		12310
105000104							3625		3625
105000124							20875		20875
105000133							16105		16105
105000134							2550		2550
105000137							1511		1511
105000147							8265		8265
105000149							8756		8756
							134608		37187
									97421

FIG. 5—AGED ACCOUNTS RECEIVABLE TRIAL BALANCE.

BARNES HOSPITAL
SALES - 2

JOURNAL VOUCHER REGISTER - 3

FIG. 6—SALES JOURNAL.

GENERAL FUND CASH	31511303	115276	3746701
CASH ACCTS REC MC MILLAN	31511411	1152768	363736800
DIETARY	3151141300		3300000
RECOVERY	3151203000		10573500
ITEMIZED STATEMENT	3152040000		300000

FIG. 7—CASH RECEIPT JOURNAL

2. Balance forward card.
3. Charge card.
4. Credit card.
5. Cash receipt card.

The patient's weekly statement is designed in continuous form or fan-fold style; therefore, after the punch cards have been placed in the tabulator and the statement aligned in the printing carriage of the tabulator, the patients' statements are printed automatically and continuously. In this application about 700 weekly statements are prepared and, on completion of this run, are then ready for distribution to the patients in the house.

At the close of each month, and from punch cards previously used and in file, a trial balance of the unpaid patients' accounts receivable is prepared in proof of the general ledger controlling account, which is a customary accounting procedure. However, in addition to the listing of each individual account, there also is obtained simultaneously a tabulation of the age of these accounts. This report (fig. 5) is called the aged trial balance and is headed to produce the desired breakdown of patients' accounts receivable, namely, current accounts, 30 day ac-

counts, 60 day accounts, 90 to 180 day accounts, and accounts prior to 180 days.

The column headed "Charity" is provided for listing of charity accounts, on such patients who are still in the house. The columns headed "Bad Debts" and "Attorney" are provided for separate trial balances run on these classes of accounts.

The aged trial balance forward card is used in the preparation of this particular report.

As discussed earlier, the charge card or debit transaction card is used to designate the class and amount of debit posting to the patient's account, such as room and board, operating room, and similar charges. This same card is used in the preparation of the sales journal, which is a daily recapitulation of all charges to patients by type of income. This particular form is used for three purposes, namely, Cash Receipts, coded as No. 1; Sales Journal, coded as No. 2, and Journal Voucher Register, coded as No. 3.

The journal voucher register will be discussed in the section relating to the general ledger application.

The headings on the sales journal (fig. 6) show the account name, the

entry date, hospital to receive credit, income account number, daily sales amounts and month-to-date total. Therefore, at the close of any month, the last run of the sales journal automatically produces the final totals for that month. This procedure is repeated each month.

The cash receipt journal (fig. 7), coded No. 1 on the same form as the sales journal, is tabulated in much the same manner as the sales journal. In the preparation of this record, the same cash receipt card is used which was prepared at the time payment was received, and used previously in the preparation of the patient's ledger account and other income accounts affected. This journal is tabulated to show the total amount of cash received and to distribute such receipts to patients' accounts receivable controlling account and other income controlling accounts as they may arise.

All cards and forms now have been discussed in a general manner in connection with the patients' accounts receivable application, including the sales and cash journals, and the accounts receivable aged trial balance. The details of the application will be described in the succeeding chapter.

The doctor clarifies a point by the use of x-ray film which lends itself well to television because every detail can be seen by the audience.

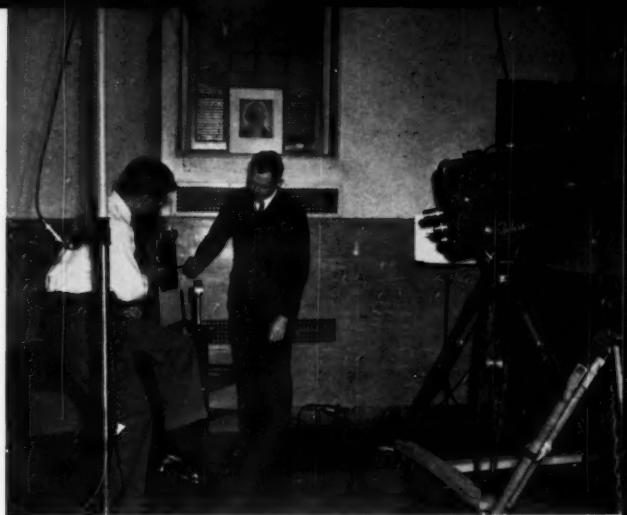


IT IS not quite three years since the first operation was televised at the Johns Hopkins Hospital in Baltimore. In describing this experiment in the use of television as an aid in teaching surgery, James E. Hague and Dr. Edwin L. Crosby wrote, "Television may not be the whole answer to the problem of graphic teaching of surgery, but there can be little serious doubt that it is part of the answer."* So important a part was it considered that when the new operating rooms of the hospital were opened in May 1948, they were all set up for television.

While much has been written about the use of television in the teaching of surgery, little, as yet, has been reported about its use for teaching in other fields of medicine. On Nov. 10 and 11, 1949, the New England Center Hospital, a unit of the New England Medical Center, Boston, presented a telecast of six medical clinics and a surgical procedure for the New England Postgraduate Assembly. Because this is a new application of television as a teaching medium, and one which will undoubtedly be used more and more, it might be of help to others to know something of the first-hand experiences here at the Center Hospital.

Putting on a television show is similar to building a hospital. When the hospital is built, you know what you should have known before you started, but by then it is too late to make changes. So, too, in televising medical clinics from a hospital—after the show is over, you realize what you should have known before you even started!

*Hague, James E., and Crosby, Edwin L.: Television, Newest Aid in Teaching Surgery, *Mod Hosp.* 70:65 (April) 1948.



TELEvised CLINICS

are as useful for teaching medicine

as they are for teaching surgery

RICHARD T. VIGUERS

Administrator
New England Medical Center
Boston

MARJORIE L. SHEA

Public Relations Officer
New England Medical Center
Boston

The televising of this program was done by the Radio Corporation of America, and it was presented through the courtesy of E. R. Squibb and Sons. The program was carried by cable from the hospital lecture hall and operating room to the hospital roof, on by microwave to the John Hancock Building, the tallest building in the city, then on to the Copley Plaza Hotel where it was projected simultaneously on a large 6 by 8 foot screen and several smaller sets before an audience of some 250 doctors.

After preliminary meetings with the committee of the New England Postgraduate Assembly to determine the types of clinics that would be most interesting and that could be most effectively presented, it was decided to have a clinic on respiratory resuscitation given by the anesthesiologist; a neurological clinic by the neurologist and the neurosurgical service; a clinic on the diagnosis and treatment of poliomyelitis by the polio-

myelitis clinic of the Children's Hospital Medical Center; a spleen clinic by the hematologist; a demonstration of the measurement of thyroid function by means of radioactive iodine by the endocrinological group; a therapeutic conference on heart failure by the internists, and a splenectomy by the surgeon-in-chief.

Next, a meeting was held with the representative of RCA to determine the location of a room to be used as a studio. One of the lecture halls proved adequate for this purpose since, in addition to having three entrances, there was a space approximately 24 by 24 feet that could be cleared. One of the operating rooms was selected for the surgery, and a small area approximately 8 by 8 feet was set aside as the television control room. It was necessary to check the electric current available to supply the required amount of electricity of the right type for the power needed in the operation of the television equip-



Left: A neurological clinic was presented by the neurological and neurosurgical services. **Right:** The program was projected simultaneously on a large 6 by 8 foot screen and on several smaller sets before an audience of some 250 physicians.

ment. About a week before the telecast, the equipment arrived and a space of at least 20 by 30 feet was required for storage. We were fortunate in having an unfinished area, about 40 by 20 feet, where all the equipment and the television sets could be locked up and fully protected.

In addition to the crew of eight men sent by RCA to handle practically all of the work incident to the setting up of the equipment, two electricians and a carpenter from the hospital maintenance crew were needed to assist them in running their cables and in running in special lighting circuits to the lecture hall which was serving as the "studio." Obviously, it takes a large amount of lighting to give the proper illumination for the studio, and we succeeded by tapping three different electric circuits to provide the necessary current. If the studio had been located at the end of a hallway where there was only one current immediately available, we would have had a serious problem because the lines and fuses are usually not adequate to take care of this special load.

It was found desirable to suspend the television cables, running from the control rooms to the studio, from the ceiling in order to allow space in the area for carts, ambulatory patients, and bed patients being moved to the operating rooms, and for other hospital traffic. We were fortunate, for the most part, in having enough access panels in the ceilings of the corridors so that we could open these panels and wire the cable to a support inside the access panel in the ceiling. Where this was not possible, we used a 2 by 3 inch beam to hold the cables against the ceiling.

A television show is a real show in every sense of the word. It cannot be put on without some rehearsal. The individual clinics held rehearsals and then, the day before the telecast, we had a dress rehearsal, working with the television cameras, but telecasting only to monitor sets within the hospital. This rehearsal was absolutely essential, not only to familiarize the doctors with the conditions they would have to meet and to show them what could be properly televised and what could not, but also to familiarize the cameramen with the program to be presented so they could be ready to focus on the right things and make shifts between cameras. On the first day of the two-day program we had two cameras available in the studio, a minimum essential to a smooth performance. On the second day one camera was set up in the studio and one in an operating room and the result was a much rougher presentation in the studio because in changing from one object to another, the single camera showed many blurs.

Rehearsal day is a good time to hold the press conference for it is possible to interrupt the program for pictures at that time without seriously affecting the performance. Such a program has considerable news value and an interesting story giving the details of the television setup as well as the educational purposes of the program, together with pictures, should be pre-

pared in advance and given to the photographers and reporters at the time of the press conference.

It is important to have a special release for televising signed by all the patients presented in the television clinic. This release should be made broad enough to cover the various agencies participating, and also to cover newspaper publicity even though the actual program is televised over a restricted channel as was the case in the program for physicians attending the postgraduate assembly.

As we worked out our first television program, step by step, we jotted down random facts to guide us in the future. The following observations resulted from our first venture in television at the New England Center Hospital:

1. All charts should be prepared in the relation of three units high and four units wide; that is, if the chart is 40 inches long, it should measure 30 inches from top to bottom. This is not always possible, especially in cases of x-ray film, but when it can be done, the chart fits the television screen. It is also desirable to have a gray background on any posters or charts since a white background reflects the light and interferes with the clear presentation. Photostats do not reproduce well over television because of their shiny surface. X-ray films, however, lend themselves perfectly to television and every detail can be seen distinctly by the audience. Some colored slides, 4 by 4 inches, were used, and these were highly satisfactory and enabled the audience to see the structures without difficulty.

2. Some of the clinics should begin on the exact minute for which they

are scheduled. For example, the surgical procedure can be timed to start at the agreed time, but in order for the patient to be prepared and anesthetized and for the preliminary incision to be made, a cooperative effort is required so that the surgical group can be ready and be televised at the scheduled time. Since some of the clinics will not run for the exact time allowed, it is advisable to have them scheduled before the surgical procedure. For example, we started one day with a 30 minute spleen clinic at 10 o'clock. The splenectomy was scheduled on the telecast to begin at 12 o'clock. The demonstration shown after the spleen clinic was scheduled to run from 11 to 11:30 but ran only 20 minutes. It was, therefore, necessary to run the next clinic, a round table on heart failure, from 11:20 to 12 o'clock to fill in the time. This was easy to do with a round table discussion, but if we had scheduled a demonstration or a clinic that was not flexible as to time, we would not have been in a position to make the switch-over to surgery as scheduled.

3. It is important to work out in detail the change from one clinic to another. Equipment must be moved in and out without interrupting the show, and this can be done by having the camera focused on the man introducing the clinic while the shift is being made. We found it helpful to make a little sketch that could be followed by the cameramen, with a duplicate for the man at the control panel, showing on just which person or object the camera would be focused while the shifts were being made.

4. If there are two cameras available for the operating room the results will be more satisfactory because it will be possible to shift from the fixed camera, which shows only the operating field, to a studio camera, which would show the whole operating room and/or details, such as the work of the anesthesiologist. We found it a satisfactory arrangement to have the surgeon wear a small microphone under his mask and to give the running comment on the surgical procedure. In other telecasts it has been found equally, if not more, satisfactory to have another senior surgeon give the running comment and to switch the microphone over to the operating surgeon for whatever additional comments he deemed advisable.

5. A dress rehearsal should as closely approximate the real perform-

ance as possible. For example, the patients should be presented in the clinic and, in surgery, an actual surgical procedure should be carried out, for only in this way is it possible to detect problems and difficulties that may arise when the actual show is in progress.

6. The use of microphones in the clinics presents a problem. The simplest solution seems to be to have a hand microphone held by the person who is speaking and then turned over by him to the next speaker. When the physician who is speaking requires both his hands to demonstrate a procedure or examine a patient, the microphone can be held by an assistant. We used this type of microphone and also a microphone suspended from the boom. This combination requires trained personnel to move the boom and, at best, is likely to pick up a considerable amount of noise from the movement over the floor. It also makes for complications in the control room, since the personnel there must be cued to make the shift from one microphone to another.

7. It is helpful in the interests of smooth performance if the doctors give the television cameramen advance warning of shifts. For example, if a doctor is going to show an x-ray film, such a remark as, "Now if we can move over to the viewing box," gives the cameramen time to make the necessary switch, whereas, if the doctor

just suddenly takes off for the viewing box, the camera remains focused on thin air.

8. A simple but important *must* is that all speakers should look at the camera, for only by so doing will they be looking directly at their audience when the program is televised.

9. There should be two persons responsible for the coordination of the activities in the studio and the operating room. We had the head of the television crew act as floor manager in the studio, and a senior resident serve as contact man between the operating room and the control room.

10. In the last analysis, the success of the program depends upon the competence and cooperation of the man directing the entire television project. We considered ourselves most fortunate in this respect to have the direction of our program in the hands of Walter L. Lawrence of RCA who not only handled the technical matters involved, but also had a complete grasp of the entire problem of televising medical clinics.

Our first experience in televising medical clinics has given us more than a familiarity with the procedures involved and some knowledge of the problems to be met in putting on such a program. It has brought to us a realization of the potential uses of television not only in surgery but also in other fields of medical education.

ADMINISTRATIVE CAPSULES

IN NO OTHER SPHERE of executive life do you find the continual challenge of emergency situations that you find in the modern hospital. It is literally true that every case is a law unto itself, that it is without precedent and that it requires accuracy of judgment on which life itself depends.

THE TENACITY AND STUBBORNNESS of prolonged illness must be matched equally by tenacity and stubbornness in our medical and social scientists who deal with it.

PUN OF THE MONTH: "Shoemaker stick to your last" does not apply to the hospital executive who deals with such a variety of lasts, souls and heels.

WHEN SOCIETY made the decision that patients, lacking financial means with which to purchase adequate care, could not be treated at home during illness with the best results, and considered it in the interest of the sick (and incidentally, in the doctor's interest) to herd them in to wards where they could be treated on a time-saving and efficiency basis, an extraordinarily great risk and responsibility were assumed.

PATIENTS WHO DO NOT NEED A HOSPITAL BED and are homeless belong in an intermediate type of institution—a substitute for the home—under the protecting wing of the hospital which radiates medical care in their direction, as necessary, by an extramural hospital program.—E. M. BLUESTONE, M.D.

The hospital runs smoothly on a

PLAN of the DAY

GEORGE H. HOLMES

Administrator
Ingleside Hospital
Cleveland

I FELT bright and shiny in my navy lieutenant's uniform that January day Uncle Sam called me to active duty. Saying good-bye in the station, everyone was reassuring and hopeful. The president of the board of directors patted me on the shoulder and said, "We'll be all right until you come back. If the cadet nursing program produces and if we can fill in with aides, we'll get by." And get by our little hospital did—just.

In short terse paragraphs and wistful forlorn notes, I learned of the trying times Ingleside Hospital for mental diseases had during the war. I soon understood that all hospital administrators who stayed behind to keep the home fires burning battled to keep alive the spark of cooperation and unity that is a hospital. It troubled me at a distance of ten thousand miles and it troubled me after I returned. Everything has come easy in hospital work since Pearl Harbor save one thing—*personnel*.

PHILOSOPHY HAS CHANGED

Any hospital whose chief goal has been service to the community has had to face up to large ugly facts brought about by changes in philosophy, economics and human nature. We have learned that a large segment of our female population no longer finds the nursing profession attractive. Why? Fill in your own reasons. I have a dozen.

We have learned that a 300 per cent increase in salary for orderlies, attendants, scrubwomen and cafeteria workers offered no inducement to work in a hospital. We have learned that regardless of training or experience, hospital work is not being done the way a capable administrator or doctor wants. It seems a sick person no longer has the same call on the divine spark of humanity which traditionally burns in the human breast. Short

hours, uniforms, sick leave, vacations, pensions, hospitalization, benefits, rights, privileges and social equality instead of stimulating people to seek us out for jobs seem to have worked in reverse.

We all know stories of hospital directors and administrators who ran laundry equipment or spelled the dishwasher.

If you concur in the foregoing, then your soul is also scarred with each report of a pressure sore, a hypodermic abscess, a fecal impaction, an unchanged bed, a dirty bedpan, a cold tray, a missing pedicure, a pitcher of lukewarm drinking water—in short, an unhappy patient.

Not long after I returned, I inventoried our personnel and carefully evaluated each job and operation in the hospital with an eye to licking the ennui and neglect which the war left in its wake. Every turn of the road brought me back to that single imponderable—the human being and his perverse nature. New equipment and better technic made for easier, more satisfying tasks. Patience, tolerance and greater sympathy made supervisors and directors easier to work for. Why, then, had service to the sick become a calloused, unglorious hodge podge? I was determined to find the answer.

I found an analogy in the ship I sailed for Uncle Sam. There we took raw recruits, six weeks away from civilian life, and molded them into a fighting crew, capable of performing a hundred intricate tasks, from repairing motors and engines to chipping rust on the decks. I remembered that the soul of each day's operations on the ship was a thing called the "Plan of the Day." As executive officer, it was my job to draw up this plan and

see that it was distributed throughout the ship and meticulously followed. I wondered if it was possible to work out a similar plan for the hospital.

The medical director, the house-keeper, the dietitian, the nursing supervisor and I outlined the duties that came under each head. It was apparent that we could tie all the diet and house-keeping functions to the nursing administration for purposes of planning. We then set up a master plan outlining the broad functions of the hospital for each day in the week. We set up a chart of the hospital and its 105 beds. We then divided the hospital into stations with varying numbers of beds. Stations where patients were untidy or required complete bedside nursing had fewer beds than did those where patients were ambulatory. For each station, we prepared a routine book listing procedures and schedules to be followed. As I look back on the formative stage, it seems like a great deal of work inasmuch as we had to have a different master plan for each day of the week and a new routine schedule for each station for each day of the week.

PLAN POSTED EACH DAY

The master plan was posted at the bulletin board where each shift reported for duty. Under the simple "Plan of the Day" heading we listed:

1. Supervisor in charge of nursing.
2. Medications nurse.
3. Charting nurses.
4. Station assignments listing individuals.
5. Persons off duty.
6. Visiting doctors.
7. Rounds and reporting routines.
8. Turn exit lights on or off.
9. Check in keys and thermometers, time.
10. Key boxes, scissors, check in.
11. Admonition to check nursing routine in station book.

12. All aides and nurses to answer emergency calls.

13. Charge nurses to make report to nursing office.

14. Request for suggestions.

At each station we installed the routine and procedure book. It listed the following routines with instructions for each:

1. Hours of rounds.

2. Time for T.P.R. check.

3. Visiting doctors.

4. Bedside care.

5. Patients allowed visitors.

6. Time for progress notes and nursing notes.

7. Mealtime and relief provided.

8. Time and place of staff meetings.

9. Enemas.

10. Shampoos or manicures.

11. Supplementary work, such as making pads, clearing drawers.

12. Weighing days.

13. Administrator's (captain's) inspection.

14. Number of beds assigned and scope of work.

Later we carried our plan a little farther when we assigned locked closets to each station. Each morning the central supply department

would collect requisitions and fill the station's closet with linen, alcohol, green soap, talcum powder, bandages, pads, toilet paper, towels and soap.

Before launching the plan we called a general meeting of the entire staff, including everyone who could be spared from duty. We outlined and reiterated the general philosophy under which the hospital operated in the community. We cited, frankly, where we thought the hospital failed in its functions. In this rousing pep meeting, we sold the members of the staff the idea that the "Plan of the Day" would make their work simpler, relieve them of administrative responsibility, reduce the time spent overlapping or chasing supplies, and, finally, get the nurses and attendants closer to their individual charges. We discussed the losses the hospital was suffering from carelessness or thievery. We declared the patients' right to the finest care possible. We emphasized that the plan was designed to give the staff proper recognition for work well done.

After a shakedown, with a few changes for smoother operation, we set up our toughest nursing ward as a training ground under our finest

nurse. Every nurse and aide was assigned here for a refresher course and then returned to a regular station. The plan has been in operation for several months with results far beyond our fondest hopes. Each new employee is started in our training ward and thoroughly indoctrinated with Ingleside's philosophy. If the quality of work lags, we have several ways of picking up the laggard before serious damage is done. If a refresher course will effect a cure, it is prescribed. So thoroughly has the idea taken hold that we have real *esprit de corps* in the hospital. Each station takes great pride in the looks and results on the floor. Inspection Day is a great occasion now. There is a genuine pride in the work, and competition among stations has provided additional incentive that was lacking before.

The foregoing is not to be interpreted as a cure-all for every administrator's personnel problems. I honestly don't know whether the plan would work in a 1000 bed hospital. I do know that if I had a 1000 bed hospital, I'd give it a whirl and run it as the navy runs its ships and stations.

REPORT A.C.S. MAY DROP HOSPITAL PROGRAM

Chicago.—The hospital standardization program of the American College of Surgeons may be turned over to the American Hospital Association or the American Medical Association, it was reported here last month. Trustees of both organizations are considering proposals looking toward abandonment by the college of the hospital approval program it inaugurated more than 25 years ago, it was learned.

The approval program for hospitals was developed and directed for many years by Dr. Malcolm T. MacEachern, who became director emeritus of the college last March when Dr. Paul R. Hawley was named director. Dr. MacEachern is expected to retire from the college staff if arrangements to transfer the hospital program to another organization are completed.

Meeting in San Francisco late in June, officials of the A.M.A. were expected to consider the advisability of taking over the college standardization activity as an associated program to the intern and residency approval program conducted by the A.M.A.'s council on medical education and hospitals.

Trustees of the American Hospital Association, it was reported, have been considering ways and means of taking over the college system of inspections and evaluations aimed at maintaining high standards of administrative performance in the nation's hospitals.

Publicity Goes to Their Heads

Shadyside Hospital's Easter Hat Prevue Is Fun for Everybody, Draws Crowds and Makes Newspaper Headlines for Hospital

JUST for fun—a Spring Tonic for everyone!" That's the reason for the Easter Hat Prevue at Pittsburgh's Shadyside Hospital, according to public relations director Kathryn Power.

Everyone connected with Shadyside is invited to participate, Miss Power explains—patients, personnel, students,

special nurses, friends—and everyone enters into the spirit of fun.

"We had our first Prevue in 1949, and it was one of the most popular and entertaining features we ever had," Miss Power said. "Trustees, doctors, patients, visitors and personnel were among the interested spectators. We had many favorable comments from

others who saw the newspaper pictures and television show."

In addition to the hospital hats created by Shadyside employees using materials from their own hospital departments (see below), the exhibit featured real Easter hats and another section showing nurses' caps from more than 40 different schools.



"Operation 1950," designed by the operating room staff, is shown here by Roberta Budin, dispensary nurse.



Naomi Rosenkranz wants to know if maintenance staff's "Rainmaker" will get Mary Johnson all wet.



The pharmacy staff at Shadyside made the "Pill Box," worn here by Mary Lou Johnson, social service.



Modeled by Isabel Tarratt, the "X-Ray Special" features lead-foil, film and instructions for patients.



Dr. Laura Blair, house physician, helps lab technician Doris Wissman model the surgical staff's creation.



"Knockout" is the apposite name anesthesia staff gave creation worn by the anesthetist, Dorothy Braun.

MR. ADMINISTRATOR, R.N.



MR. ADMINISTRATOR, R.N. isn't as unthinkable as it appears! The board may be considering a male candidate with an R.N. after his name for the executive post of a hospital. "Unusual!" the committee on appointments may protest. But should it be? Perhaps we have been conditioned badly while overlooking this source of executive material till now. We seem to have shied away from it.

Male registered nursing as a background for hospital administration has become more acceptable since the war and it has influenced, to some degree, the growth of university courses in this subject. One out of six members of the graduating class of 1950 in hospital administration at Columbia University is a registered nurse, and of these, three out of four are men. One-third of the students in the 1950 class in hospital administration at Yale University, all men, have an R.N. attached to their names. Similar courses in other universities reveal similar pictures.

WHERE THE TREND STARTED

Whether this manifest trend is one of the end results of the depression years of the 1930's, during which many alert and promising young men entered nursing schools for lack of funds to undertake full college training, or whether it is the result of planned intensified efforts to recruit men students to combat the shortage of women candidates for nursing schools is difficult to determine.

That the war encouraged this trend is undeniable. During these years hundreds of men registered nurses were incorporated into the various military medical services and in most instances earned duties of an administrative nature. This stimulated interest in the administrative aspects of medical care in these individuals. At the same time new vistas were opened to a group of qualified men who, in nearly all cases, would have been un-

Mr. Smith was formerly administrative resident of Montefiore Hospital, New York City.

An R.N. after his name is no handicap to a man entering hospital administration. In fact it is an asset, says a former male nurse

MALCOLM SMITH

Administrator
Richmond Memorial Hospital, Dreyfus Foundation
Staten Island, N.Y.

able to progress to top administrative positions within the framework of the nursing profession because of the strong influence of tradition. The rapid growth of university courses in hospital administration since the war has aided such men in obtaining the necessary academic background for executive work.

Why, you will ask, are not women nurses represented proportionately in these academic programs to develop hospital executives? The answer seems to be this: women registered nurses have always been able to rise to executive positions within the framework of their own profession, as evidenced by directors of nursing service, directors of nursing schools, directors of visiting nursing groups, directors of public health nursing groups, and top army, navy and Veterans Administration positions, whereas, with notably few exceptions, these opportunities have been closed to men. Also, qualified women registered nurses have always been able to obtain the necessary academic training required for these positions in the numerous university graduate nursing programs. The opportunities within the nursing field for women with administrative ambitions have not been restricted and the demand for formal training in hospital administration *per se* has therefore not been as great.

Some leaders in the hospital field have from time to time raised the question of men in addition to women for executive nursing positions. For example, Dr. E. M. Bluestone in a short article entitled "Rate Yourself, Mr. Administrator,"¹ in which he was recording a few stimulating ideas in the interest of hospital progress, wrote,

¹Bluestone, E. M.: "Rate Yourself, Mr. Administrator." Mod. Hosp. 67:63 (December) 1946.

"What would you think of medical executives (men) as superintendents of nursing and principals of training schools in large hospitals?"

Nurses represent the second largest group in the field of hospital administration. In 1943 there were 6655 hospital administrators in the United States; 40 per cent of these were physicians, 34 per cent were nurses and 26 per cent were laymen.² These figures did not include assistant administrators. The majority of the physicians were in the large hospitals while the majority of the nurses were in small hospitals, having progressed from the nursing division of the institution to the administrative post.

HOSPITAL TRAINING IS BEST

It is generally accepted, particularly among faculties of university courses in hospital administration, that an individual whose education was partially acquired while in residence in a hospital, all other factors being equal, makes a better administrator than does the one who lacks such residence. The broader the education in the various hospital disciplines the better. This observation is reflected in the foregoing figures, in which doctors comprise the greatest number, nurses the second and laymen the third. As Goldwater wrote: "the students permitted to participate in this work (hospital administration) should be graduates in medicine."³ The pre-administrative training in nursing that some men carry into the province of hospital administration is therefore no handicap. It is, in fact, an asset.

Where do men obtain nurse's

²Lewinski-Corwin, E. H.: The American Hospital. New York: The Commonwealth Fund, 1946, p. 132.

³Goldwater, S. S.: On Hospitals. New York: Macmillan Co. 1947, p. 27.

training? Although many hospitals throughout the country offer training to men in nursing in conjunction with their training school for women, only four schools offer training for men students exclusively. These are the Mills School, an affiliate of the Bellevue-N.Y.U. Medical Center, the Pennsylvania School of Nursing for Men, and the Alexian Brothers' Hospital schools of nursing in Chicago and St. Louis, both of which have university affiliations. In these schools, and others, such as the Jersey City Medical Center and the McLane School of Nursing in Boston, men receive essentially the same training that is given in the best three-year nursing courses, with the exception that Psychiatry and urology are emphasized

more for men than for women students, and that obstetrics and gynecology are presented to men in theory only. Great Britain has released some figures showing that it now has 157 nursing schools which admit men students and a ratio of men to women of 1 to 5.⁴

How successful are these men as administrators? A comparison of the success of recent graduates in hospital administration who have a nursing background with that of those who do not is of little value because almost all of the graduates have thus far been successful. In reviewing individual experiences, we find that many men with

⁴ Watt, Katherine: Men Nurses in Great Britain, Am. J. Nurs. 49:692 (November 1949, p. 692.

a nursing school background are now holding high positions in various hospitals throughout the country and building a reputation for themselves in the broader field of community health planning.

The fact that some men administrators have a nursing education is fairly well known in nursing circles, but perhaps less so among directors of hospitals and trustees generally. A useful purpose may therefore be served by giving one of the possibilities for the recruitment of the new generation of executives wide publicity. No one should be surprised if the next decade turns up a new group of successful hospital executives who are proud of the R.N. which gave them their start in a great hospital career.

BLUE CROSS DRIVE in Leavenworth

brought the whole community into the act

HENRY J. MEINERS

Superintendent
Cushing Memorial Hospital
Leavenworth, Kan.

ment only if they received reasonable assurance that such a cross-section of the health of the community would be enrolled. It was felt that to do this an organization would have to be set up that could enlist enough volunteer workers to call on every family in the city to explain these plans and offer everyone an opportunity to enroll.

The two hospital administrators invited representative people from the community to a meeting to consider whether such a program might be carried out. Included in this initial group were the mayor, a representative from each civic club and professional society, members of the County Medical Society, Blue Cross employee group leaders, representatives from the schools and churches, and others interested in seeing these health plans offered locally.

Out of this original discussion group, a citizens' committee headed by Walter Read, manager of the water department, was set up. The city was divided into eight districts; a chairman was selected for each district, all to be coordinated through Mr. Read.

Meetings were held in the city hall, and in schools and churches all over the city. The Blue Cross-Blue Shield field staff attended these meetings, giving full explanation of the scope and purpose of the services.

Prior to the actual work of calling on each individual, everything possible was done to acquaint the community with the meaning of the opportunity that was about to be its.

PARENTS ASKED TO HELP

All teachers of both public and private schools were called to a meeting, furnished a supply of pamphlets explaining the services of Blue Cross and Blue Shield and told of the significance of prepayment as a way of continuing financial support for their local health institutions. They were asked to explain this to their pupils as a social science study and to request each child to take a pamphlet home and also one for a neighbor who did not have a child in school. Each pupil was also given a letter to take home, explaining the campaign and asking the parents to fill in their names as volunteer workers. These letters were returned to the schools.

Special meetings were held for employe group leaders interested in en-

LEAVENWORTH, one of the oldest cities in Kansas, is served by two community hospitals. St. John's is operated by the Sisters of Charity, and Cushing Memorial, by a nonprofit board of directors.

Early in 1948, the administrators of both hospitals invited Warren Healy, enrollment and public relations director of the Kansas Blue Cross-Blue Shield plans, to help organize a community-wide enrollment campaign in Leavenworth. Similar campaigns had already been organized in more than half the counties in Kansas.

FIRST CITYWIDE CAMPAIGN

These drives had usually been sponsored for rural areas by the County Farm Bureau and in urban communities by civic clubs and other groups of public spirited individuals. But theretofore, no city in Kansas as large as Leavenworth with a population of more than 20,000 had offered Blue Cross-Blue Shield membership on a citywide basis.

Mr. Healy stated that the success of an enrollment program consists in obtaining a cross-section of the health of the community. He said that Blue Cross and Blue Shield could accept unrestricted community-wide enroll-

larging present groups or starting new ones.

The newspaper ran daily items citing cases that had benefited from the use of their Blue Cross membership and quoting statements by the hospital administrators, physicians, the mayor and various leaders working in the drive. Such items were continued prior to and throughout the campaign. Most of the business houses having Blue Cross groups contributed toward a full page advertisement endorsing the campaign, urging full support by all. The Leavenworth Medical Society announced its endorsement and active support not only in the news columns of the *Leavenworth Times*, but in a paid advertisement signed by all physicians.

All of the organizations originally represented at the organizing meeting were asked to furnish members to act as section and area leaders for each of the eight districts.

The two hospitals prepared on 3 by 5 inch cards the names of Blue Cross members who had benefited under their service. They were divided according to addresses in the eight districts and passed out to the chairmen. These were individuals who could fully appreciate the services. They were asked to volunteer for calls in the homes. Names of parents turned in by the school children were also passed on the district chairmen as volunteers.

TALKED ABOUT BLUE CROSS

All of Leavenworth was soon talking about Blue Cross and the campaign was held March 1 to 10, 1948. The two hospitals serving as information centers helped to obtain volunteer workers, explained the services to all who inquired, and took the names of those interested in membership. Extra volunteers were dispatched to the homes of those who were interested but had not been reached. The hospitals answered questions pertaining to forming new employee groups and arranged for a Blue Cross field man to meet with potential groups. All volunteer workers obtained extra supplies at one of these centers and enrollments were accepted at these locations on the last day of the drive.

In December 1949, the two hospital superintendents again felt that Blue Cross-Blue Shield enrollment would be worth while. The Lions Club accepted the responsibility to act as co-sponsor under the leadership of its



Enrolling a new member into Blue Cross and Blue Shield at Cushing Memorial Hospital on the last day of Leavenworth's second drive.

president, Jack Mitchell. The Business and Professional Women's Club became the co-sponsor under the leadership of its vice president, Mrs. Lois Binderim, office manager of Cushing Memorial Hospital. The same general plan of organization to obtain volunteers and to call on individual homes was adopted. This time the two clubs furnished co-chairmen for each of the eight districts.

It seemed that the groundwork done in the first drive had produced some lasting effect. The Immaculata High School Mothers' Club came forward with an offer of 50 volunteer workers. The Parent-Teacher Association Council offered to supply workers. The Leavenworth County Medical Society again gave support and endorsement of the drive by a paid advertisement signed by its members. Mayor Ted L. Sexton endorsed the effort and stressed the fact that these two hospitals took care of all of Leavenworth's hospital needs without one cent of direct tax support. Many of the people who had first learned of the value of these services during the earlier drive now not only wanted to join, but offered to serve as volunteers.

The results of the drive were both tangible and intangible. Enrollment in Blue Cross was increased in the city and county of Leavenworth to 30 per cent in the first drive and more than 40 per cent in the second.

The ability of the community at large to use its hospitals and thereby enable them to serve and be paid for their services has been assured. But a much greater value has resulted in this community. Hundreds of volunteer workers in Leavenworth now have a personal interest in both providing and maintaining adequate hospital and medical facilities for the community. The feeling of partnership with doctors through Blue Shield services and hospitals through Blue Cross is strong. Furthermore, many who were contacted and still do not have protection of this kind have had an opportunity to discuss and read about these plans and now understand what Blue Cross and Blue Shield can do for them. When they do decide to obtain such protection, they will be inclined to go along with their own community's plan and not put their money and faith into something that may not adequately cover them.

FOUR OUT OF 10 COVERED

Now with four out of every 10 admissions covered with Blue Cross, the hospitals feel the improvement in their financial condition and thus their opportunity to serve. A substantial amount of their regular expenses is guaranteed. The hospitals are proud to have done their share in promoting this partnership in the interest of good health in their community.



STRICTLY CENTRAL SERVICE

*is provided for this 100 bed hospital
that serves Comanche County, Oklahoma*

PAUL HARRIS

Architect
Chickasha, Okla.

THE Comanche County Board of Commissioners instituted work on the Memorial Hospital in the summer of 1948. The building and its facilities were to serve the 1080 square miles of Comanche County, Oklahoma, and its present population of 60,000. The hospital is at the county seat, Lawton, a city of 36,000.

The site is approximately 10 acres of prairie land west of Lawton. A principal highway of that region runs along the southern boundary of the property, and the building was placed upon the highest point of the site approximately 14 feet above the highway. Present and predicted expansion of Lawton will bring the center of the city nearer to the location of the hospital.

Funds for the construction were obtained by a county bond issue covering two-thirds of the necessary sum as estimated, and federal assistance for the remainder. The affairs of the Memorial Hospital will be administered by a group of citizens appointed by the county board of commissioners.

Provision was made for 100 beds. Facilities provided include medical, surgical, obstetrical and pediatric. Planning was based upon a desire to store all medical supplies in one central area and to provide simple and direct distribution to those units in which they will be used.

The entire hospital consists of four nursing units, one on each of the upper four floors. Each nursing unit is supplied directly from the central supply room on the first floor to the utility rooms in each nursing unit by means of an electrically operated dumbwaiter. All other supplies, food and patients are transported to and from each nursing unit by means of a double door elevator. The rear door of this elevator enables supplies to be delivered to the pantry, utility room, nurses' station without interfering with traffic or causing disturbing noises in the corridor.

The arrangement of the laboratory, waiting room and treatment rooms on the first floor makes this section a flexible unit. When necessity demands, the laboratory can be expanded to include any or all of the adjoining rooms.

The cystoscopic and fracture room and the x-ray room eliminate the need for two darkrooms and two control areas.

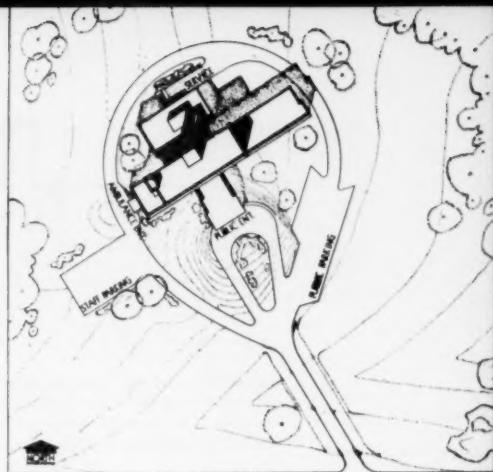
The design of the obstetrical and surgical suites eliminates the necessity of a substerilizing and supply room



GROUND FLOOR PLAN

The Modern Hospital of the Month

The hospital presented here has been selected as The Modern Hospital of the Month by an award committee. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.



OUTLINE OF CONSTRUCTION DETAILS

STRUCTURE: Reinforced concrete frame with flat slab concrete floors and roofs. Exterior walls of brick and tile hollow wall construction or of concrete. Partitions of 2 inch solid plaster. Ground floor of glazed tile.

ROOF: Built-up roofing with gravel. One inch solid insulation on roof slabs and 4 inch glass wool batts above furred ceilings.

FINISHES: Floor—terrazzo in operating suite, delivery suite, x-ray suite, cystoscopic room, emergency operating room; quarry tile in kitchen area; concrete in all storage rooms and laundry boiler rooms; rubber tile in pantries, utility rooms, toilet rooms and all other service rooms; asphalt tile throughout the remainder of the building. Wall—glazed tile throughout ground floor; ceramic tile wainscot and plaster in all corridors, delivery

and operating suites, treatment rooms, all toilet rooms, locker rooms, pantries, janitors' closets, and utility rooms; plaster in all other rooms. Ceiling—plaster in all toilet rooms, storage rooms and all basement rooms. Acoustical plaster in corridors and all remaining rooms.

WINDOWS: Architectural projected steel sash with cast stone sills and marble stools. Double glazing in operating and delivery rooms.

DOORS: Exterior—flush metal, except in main entrance, where 1 inch tempered glass doors are used. Interior—flush panel, hollow core wood doors.

HEATING AND AIR CONDITIONING: Hot water radiant heating with wrought-iron pipes in floors throughout building. North

and south wings have year-round air conditioning also.

Total project cost, including all equipment, \$900,000.

Cost per bed, including all equipment and furnishings complete, necessary for the operation of the hospital, \$9,000.

Total square foot area, 52,074 sq. ft.

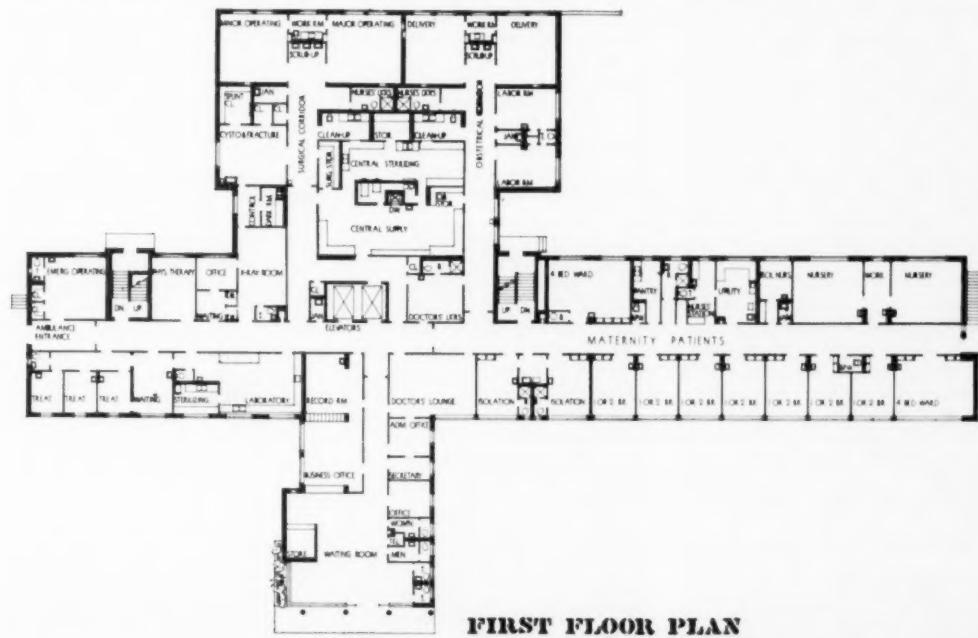
Square foot area per bed, 520.74 sq. ft.

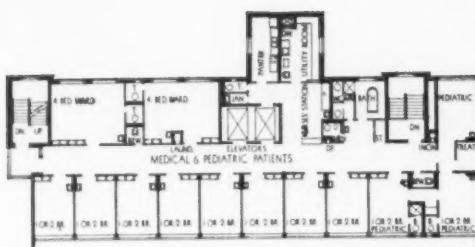
Total cubic feet, 563,931 cu. ft.

General contract price, including general construction, plumbing, heating, air conditioning, electrical wiring, kitchen and laundry equipment, sterilizers, \$722,207.

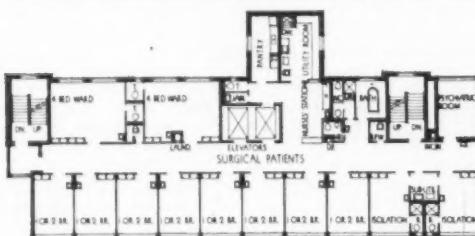
Cost per square foot based on general contract price, \$13.87.

Cost per cubic foot based on general contract price, \$1.28.





Below: Plan of the second floor on which surgical and psychiatric patients are housed. Above: The fourth floor includes a section for pediatric patients. If necessary, a section or an entire floor can be isolated for polio patients.



for one or the other of these suites. The clean-up rooms for the surgical and obstetrical suites are provided with pass windows which open directly into the central sterilizing room. With this general arrangement only one doctors' locker room is required, and it is in the immediate vicinity of the doctors' lounge.

The over-all planning of the Comanche County Memorial Hospital seems to have greatly improved upon many of the undesirable conditions that are existing in most hospitals today. Circulation of patients, visitors and supplies has been simplified. Duplication of certain rooms or areas has been eliminated.

The patients' rooms have been designed and located in a position to give each patient a maximum amount of comfort, and to allow each room to be supervised and attended by the hospital staff with minimum effort. The majority of the patients' rooms take full advantage of Oklahoma's prevailing southern breezes in the summer, and a maximum amount of warm sun is admitted in winter.

COMMENTS BY THE CONSULTANT PAUL H. FESLER

Oklahoma City

THIS is strictly a central service type of hospital. The food service is centralized to serve both the dining room and the floors conveniently. The food will be taken in heated carts to the pantries and distributed directly to the patients. The dirty dishes will also be taken back to the pantry and sent to the dishwashing room.

The central supply room on the ground floor is planned to serve the entire hospital. It is planned that all supplies—emergency linen, drugs, dressing trays, emergency suction pumps, oxygen tents—will be kept in the central supply room and transported directly to the clean utility rooms on the patients' floors, which are adjacent to the nursing station. This should minimize the need for having supplies scattered through the building. A small emergency drug cabinet is provided for each nurses' station.

The operating and delivery rooms are also served from the central supply room; the clean-up room opens through a window directly into the workroom of the central sterilizing

room. The surgical instruments will be washed and sterilized in the clean-up room before going into the central sterilizing room, but before they are used will be resterilized in the autoclave and stored in a storage room which opens into the operating suite. There is also a special window to distribute supplies to the obstetrical department.

There is no connection between the operating room and the delivery room section. This maternity department is on the ground floor so that visitors and patients will have no occasion to go to any other part of the hospital and there is no traffic through this department.

Several examining rooms are provided adjacent to the ambulance entrance which may be used for outpatients; x-ray and laboratory areas are adjacent so that they are available to both inpatients and outpatients and can be properly supervised.

The cystoscope and fracture room is adjacent to the x-ray department and is part of the surgical suite.

There is a direct connection between

the central storerooms and the kitchen so that food can be prepared before it goes into the main kitchen. This preparation section is connected with the refrigeration area. The special diet and formula rooms are in the main kitchen.

The laundry is arranged for continuous flow of linen. The soiled linen drops into the dirty linen section. It is properly sorted to go into the laundry, then into the clean section which also serves as headquarters for the housekeeper. All of the linens and housekeeping supplies will be distributed from this room.

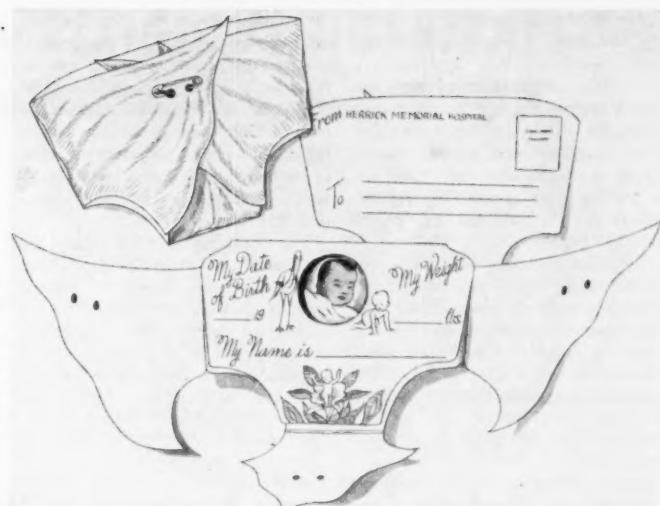
The upper floors are identical, with the exception of a section for psychiatric and pediatric patients. The bathrooms will be equipped with a combination continuous flow and regular bathtub so that a section, or an entire floor, can be isolated if the space must be used for polio patients. This hospital has been planned to render complete service with minimum effort and expense, and with minimum personnel. We think it is flexible and efficient.

Right: Novel souvenir birth announcements are sold by the hospital gift shop. Below: Photographer instructs the nurse in the operation of the camera.

THE Herrick Memorial Hospital Guild offers a new and popular feature as an added service to the mothers of newborn infants. As a public relations endeavor, a photograph of the newborn baby is presented to all new mothers to be kept as a treasured memento of the first few days of the infant's life.

Since time immemorial, such photographs have been in demand, but various complications always made the photographing impractical. Sanitary and safety factors and the inconveniencing of hospital personnel were the principal obstacles. In some hospitals the photographer takes the pictures through the nursery window while the nurse holds the baby or wheels the crib up to the window. This method obviates any possibility of break in aseptic technic, but results in a distorted picture of the infant, because of the technical difficulties encountered when "shooting" through the thick plate glass of the nursery viewing window. The procedure of holding the infant or wheeling the crib up to the viewing window not only disturbs the nursery routine, but in most instances is prohibitive because of the amount of nursing time that is used by such a time consuming procedure.

However, a new automatic camera unit, introduced in this area by Carl Dial, photographer, is constructed in such a way that the pictures can be taken without physical contact with the baby by the photographer, and with practically no interference with normal nursery routine. The camera is mounted above the small examining table used by physicians in examining newborn infants. The camera is pre-focused and aimed at the table which is marked so that the infant is placed in the area of focus. The equipment is completely automatic and is so simple any nurse can operate it. To take a picture the nurse simply presses a foot pedal, much like a dimmer switch on a car, which opens the shutter,



TAKE THEM YOUNG

and make their parents happy with a photograph

ALFRED E. MAFFLY

and

STANLEY W. VOLGA

Respectively, Administrator
and Administrative Resident
Herrick Memorial Hospital
Berkeley, Calif.

flashes the electronic light, prints the name of the baby on the negative, closes the shutter and advances the film for the next photograph. The camera is capable of photographing 325 pictures at 8 second intervals without reloading.

As a safety precaution measure, the stroboscopic bulb on the camera is covered so that in the unlikely event that it is shattered, nothing would fall on the baby. The stroboscopic light is a special, quick (1/5000 of a second), gentle light, no stronger than daylight. Doctors approved this light because, as they explained, it is completely safe for the baby's sensitive eyes.

The bulk of the camera unit is attached to the underside of the examining table and consists of a thermo control unit and the equipment that electrically moves the film. The electrical wiring is enclosed in a shock-proof metal conduit which is an added safety factor and eliminates a potential dust catcher.

Every two days the photographer comes to the hospital to pick up the film. Before he enters the nursery to service the camera unit, the photog-



raper must scrub and don a gown, cap and mask to protect the baby from possible exposure to infection.

In order to get pictures with the infants' eyes open, the nurses photograph the babies on the second day when they are well rested. Photographs are taken after their naps just as feeding time approaches. By the second day the baby has also passed the vital stage.

Before a photograph is taken, the mother must sign an authorization form. Although the procedure of taking infants' photographs has become "instantly popular" and the authorization has become a mere formality, the hospital management feels the need for

the continuation of the procedure requiring the signature of the mother.

After the infant is placed on the table to be photographed, the name is printed on the examination table with a dark wax pencil just above the infant's head. This prints the name of the baby on the finished photograph which becomes a part of the permanent record.

The photographs of the infants are returned to the maternity department within three days after birth. A guild member presents each mother with a photograph of her infant as a gift of the hospital. If the parents desire additional prints and/or enlargements, these may be purchased through the

gift shop which is located in the hospital and operated by the guild. Additional pictures are sold at nominal prices. Attractive souvenir folders and birth announcement cards are also sold in conjunction with the photographs. Any surplus realized after expenses of maintaining this service have been paid is donated to help support the part-pay activities of the Herrick Memorial Hospital Clinic which is sponsored by the guild.

The photographing of newborn infants has already proved popular beyond all anticipation, and is invaluable to the hospital both as a public relations endeavor and as an added precaution in the identification of babies.

Safety Concerns Everyone in the Hospital

OLA GLADYS HYLTON, Dr.P.H.

Assistant Director, Social Service Department, University Hospital, Ann Arbor, Mich.

DO YOU know the hazards in your job and try to avoid accident and injury to both yourself and the patients you serve? Safety is a personal matter that concerns both employer and employee.

I participated in the National Safety Congress and Exposition held in Chicago last October representing all phases of industry and living which touch the lives of 150,000,000 people. The "voice of experience" from homes, schools, farms, industries and transportation repeatedly emphasized the importance of preventing accidents, determining causes, placing responsibility, and taking corrective measures with personnel and equipment to avoid repetition.

Safety engineers stressed the fact that the foundation for all safety programs begins with interest—acquiring it, maintaining it and keeping it alive. Numerous methods which have been tried by industry were demonstrated by films, posters, equipment, slides and safety job sheets. Counseling was freely employed to correct the accident repeater. In all discussions, the rôle of the employer was given first emphasis with secondary attention given to training of supervisory personnel and developing safety attitudes in both supervisors and employees.

George H. Buck, retiring chairman of the committee on safety, American Hospital Association, stated: "During

the past several years, the A.H.A. Safety Committee has devoted a majority of its time to technicalities of hospital operating room safety. About 18 months ago a national safety program for hospitals under the joint sponsorship of the National Safety Council and the American Hospital Association was instituted. After a little over a year of modest promotion, including two A.H.A. convention exhibits, nearly 1000 hospitals in this country have signed up to participate in our safety program. Although this represents only about 20 per cent of the hospitals in the country, the A.H.A. and the National Safety Council feel quite encouraged over the progress to date. It is our plan and expectation, however, to continue the promotion of the program, the development of its services to member hospitals, and the eventual enrollment of a majority of the hospitals."

The greatest need voiced by Kent Francis, Service Industries representative of the safety council, is for "active participation by the various staffs in the hospital to contribute their technical knowledge to establish safety specifications for each job in the hospital. With this beginning, suggested measures for safety could be thoroughly tested by circularizing safety job sheets to various hospitals which, if they were found effective, would become standard safety practice."

The National Safety Council is convinced that better reporting of all accidents would provide a basis for approach to the whole problem by attacking the area in which accidents occur with greatest frequency.

How safe are patients? Can they be sure they get medicine intended for them? Is anesthesia safe? Can patients walk about without fear of slipping on highly waxed floors? Will they fall out of bed while unconscious? How do they know the building won't burn and employees will not have proper instructions for their part in removing patients?

As a part of orientation, how many hospitals instruct personnel what to do in case of fire? Are instructions in some obscure place, exits unknown and methods of notification in case of fire too cumbersome? Where are fire extinguishers? Are they inspected and filled regularly?

These and a thousand other questions enter patients' minds as they lie in bed, supposedly relaxed and resting, yet insecure and without confidence that the administrator and all of the personnel, both medical and nonmedical, will protect them.

"We could save 100,000 lives annually," Ned H. Dearborn, president of the National Safety Council, declared, "prevent thousands of accidents and save millions of dollars if we cared enough."

Special problems of RELIGIOUS HOSPITALS

studied at Catholic convention

MILWAUKEE. — With the general theme "Strengthening Voluntary Hospitals Through Regional Planning," the 35th annual convention of the Catholic Hospital Association of the United States and Canada brought more than 3500 Catholic hospital people here last month for four days of conferences on hospital and religious problems. Preceding the opening of the hospital convention were meetings of Catholic hospital chaplains, an institute for Catholic hospital pharmacists, a special conference on radiologic service and a conference of Catholic schools of nursing.

The convention was officially opened with celebration of a Solemn Pontifical Mass at St. John's Cathedral, at which The Most Reverend William E. Cousins, Auxiliary Bishop of Chicago, said in his sermon: "Not the mending of broken bones or the healing of sick bodies, but the bringing of men closer to realization of God, is the essential task of Catholic hospitals. When nurses become just workers, patients are considered only cases, and hospital buildings represent monuments to ambition, then God's plan is lost. We must serve with and for the love of God and in the spirit of sacrifice. Losing ourselves in the maze of modern medical development and making externals the end instead of a means to an end are dangers we must avoid in Catholic hospitals."

Msgr. John R. Mulroy of Denver took office as president of the associa-

tion. Msgr. John J. Healy, Diocesan Director of Hospitals at Little Rock, Ark., was named president-elect. Other officers elected were: first vice president, Msgr. E. G. Goebel, Milwaukee; second vice president, Rev. Francis P. Lively, Brooklyn, N.Y.; secretary, Sister Martha Mary, St. Clare's Hospital, New York City; treasurer, Sister Mary Seraphia, St. Louis. Re-elected to the executive board were: Sister Lydia, D.C., St. Vincent's Hospital, Indianapolis; Sister Mary Clare, St. Joseph's, Victoria, British Columbia; Sister Mary Louis, S.S.J., St. Joseph's Hospital, Toronto, and Sister Mary Fidelis, St. Joseph's Hospital, Houston, Tex. Newly elected trustees were: Sister Mary Veronica, R.S.M., Mercy Hospital, Baltimore; Sister Hilary, Holy Cross Hospital, Salt Lake City, Utah.

At a general assembly meeting on the controversial subject, "Providing Hospital Service Is Not the Practice of Medicine," Dr. M. G. Westmoreland of Chicago, secretary of the College of American Pathologists, presented the medical specialist's viewpoint. Dr. Westmoreland traced the history of hospital rates and pointed out that historically hospitals had tried to set rates as low as possible and then depended on large charitable contributions to make up deficits. He stated that certain departmental charges must result in a profit to make up for the loss encountered by low rates in other hospital services. He then

discussed the efforts of the American Medical Association to get at the basis of the problem of how certain specialists, such as radiologists, pathologists and anesthesiologists, could bill patients directly for the services they rendered. Official representatives of hospital associations, however, have shown little desire to cooperate in solving the present problem, Dr. Westmoreland asserted. "Recently, at least one representative of a national hospital association has been urging hospitals to protect the public from various so called calamities, one of which is the matter of rendering several bills instead of a single bill covering a patient's care during the period of hospitalization," he stated. He also criticized the board of trustees of the American Hospital Association for defending the status quo in the present situation. Many physicians are disillusioned regarding the sincerity of at least some groups of hospital administrators in hoping to solve the problem, he added. "Personally, I cannot but subscribe with emphasis to the principle that all fees for medical services rendered in a hospital should be collected by or on account of the physician rendering such service," Dr. Westmoreland concluded, "and all physicians concerned in the care of a patient should give or send directly to the patient or other responsible party a statement showing charges for professional services."

(Continued on Page 148.)



Msgr. John J. Barrett



Msgr. John J. Healy



Msgr. John R. Mulroy

Small Hospital Forum

VISUAL AIDS

to in-service training of staff and employees

LOWELL HUDSON

Administrator
Hopkins County Memorial Hospital
Sulphur Springs, Tex.

THE "in-service training and educational program offered at Hopkins County Memorial Hospital, Sulphur Springs, Tex., is designed principally for the following groups: all nursing personnel, graduates, practical nurses and nurse's aides, each film being followed by a brief lecture by the director of nursing service; the Practical Nurses' Association of Hopkins County, and the medical staff of the hospital.

The films to be shown are selected and previewed by the administrator, director of nursing service and the president of the medical staff. The selection is made from 30 to 90 days before the showing so that we can obtain the films we want.

The films are shown to hospital nursing personnel from 30 to 45 minutes before a change in shifts and from 30 to 45 minutes following a change in shifts. Hence the regular schedule of work within the hospital is not interrupted. Thus far, the nursing personnel is happy and enthusiastic about the program and does not mind coming a little early and leaving a little late, as salary raises are based on how

the nurse applies herself and how much she learns to do safely under the direction of the head nurse.

An average of two films each week is shown on the subjects that most need to be studied in the hospital. These include: "the proper application of heat and cold therapy"; "nursing care of the cardiac"; "oxygen therapy"; "the modified milk formula"; "taking temperature, blood pressure and pulse rate," and many others as we foresee the need.

Shortly after it opened the hospital took the lead in organizing the practical nurses of the county. The chief reason for doing this was the extreme shortage of graduate nurses. Our special duty nurses are nearly 100 per cent practical nurses and must belong to this association to be eligible to do special duty in the hospital. They meet monthly in the hospital for a well planned program. A typical program is a film on a subject such as "com-

municable and infectious diseases," followed by a lecture by one of the doctors on the medical staff.

The members of the medical staff are highly in favor of the program because it assures better nursing care of their patients. The administrator, in addition to booking films for regular monthly staff meetings, also arranges for some of the latest films on current technics to be shown at intervals throughout the month at the most convenient time for the doctors. The objection has been raised that "the doctors never have time because they have so many meetings." I might add here that the administrator must take the lead and work out some way to see that the doctors attend these showings. A little extra thought on the part of the administrator will mean the success of this phase of the program.

For example, my doctors usually say, "I would like to see the film, but just don't have time today." When the majority of them say this, I invite them to have lunch with me in the hospital dining room and have the film run during the lunch period. Sometimes I will catch only two or three at a time for a cup of coffee in my office and show the films while they have a few minutes. In other words, over a two or three day period, I see that all 10 of my doctors see the film, at a time most convenient to them, before it is mailed back.

The program is designed chiefly for the three groups mentioned; however, occasionally I will show a dietary film for dietary personnel; a public relations film for all personnel, or a safety film for all personnel.

All films for such a program can be easily obtained from the following places without cost, except for postage: the state department of health in practically every state; large schools of nursing which are glad to lend such films if proper arrangements are made; medical film libraries in various states;

Left: Lowell Hudson, administrator (extreme right), invites three doctors to his office during coffee hour to view a new film. Center: By combining lunch time and "classroom" time, doctors are able to see two films a week without interrupting busy schedules. Right: The 7 a.m. to 3 p.m. nursing shift gathers in the dining room to watch a new film.



various state and national associations, such as the heart association, tuberculosis societies and cancer research groups. However, I obtain most of my best films from the pharmaceutical companies and drug manufacturers. The pharmaceutical houses usually have films on the proper administration of various drugs that are good teaching material both for the doctors and for the nurses.

The cost of such a program is practically nothing after the initial cost of the movie projector. The local Rotary

Club of Sulphur Springs, Tex, presented the hospital with the projector and wishes to keep the program as a project by purchasing approximately two basic training films a year, such as "the Bed Bath," for showing to new personnel. Our initial cost was only \$360 and we have free films booked three months in advance. The cost is so small compared to the amount of good accomplished that no hospital is too small to adopt such a program. Every hospital, regardless of size, should and must be a training hospital

if it is to fulfill its moral obligations to the community it serves.

Ours is a 44 bed hospital with about 50 employees and an active medical staff of 10 doctors, but there is no reason why my staff, and hundreds of others the same size and much smaller, cannot see and study the same films and technics used by the largest hospitals and the best trained medical staffs of the nation. The response has been beyond our expectations. I don't believe I could stop the program now even if I so desired.

The physician's first duty is to PREVENT DISEASE

AN INTERESTING picture of "The Practicing Physician in the Field of Preventive Medicine" is presented by W. G. Smilie, M.D., in the Jan. 12, 1950, issue of the *New England Journal of Medicine*. The author's major thesis is that medicine is a social science and that the study of medicine is not a study of disease but a study of man; of an individual who is a member of a family which is part of the community.

In order to plan for the future of medicine, we must project into the future: (1) by the use of trend lines in which the history of disease for past generations is determined and the trend line is extended to the future; (2) by the use of successful procedures in greater measure.

TRENDS ARE CLEARLY DEFINED

Dr. Smilie draws some broad conclusions from some clearly defined trend lines, as follows:

1. Decline in deaths from the major acute infections of all types. The prevalence of these diseases in the community will diminish, too.

2. Decline in infant and childhood morbidity and mortality.

3. A marked increase in health problems relating to industry owing to the urbanization of our population.

4. An increase in mental diseases, especially in the older age groups.

5. A great increase in the degenerative diseases of all types.

The author predicts that there will be a demand for a different type of medical care. The community will demand an all-inclusive plan of medical service. He says that suitable facil-

ties for the care of prolonged illness and mental degeneracy must be developed. Coupled with comprehensive medical care will be a plan for preventive services.

The author states that the community will assume responsibility for the prevention of communicable diseases as it does at the present time. It will also promote the health of the worker and a suitable environment for the population and the education of the population in the principles of hygiene. It is becoming clearer that both the organization for health promotion and the actual medical services will become more and more integrated and in the future will be administered as a single unit.

On the other hand, the mass methods of prevention of illness that have been so successful in the past will not be utilized to so great an extent inasmuch as mass procedures in prevention cannot be applied to the degenerative diseases.

The author discusses the plan for the control of pulmonary tuberculosis in the future and says the major responsibility for the prevention and control rests with the practicing physician. Inasmuch as the control of the disease is determined by its epidemiology, the epidemiologic trend is as follows:

1. It will decline in both mortality and morbidity.

2. Tuberculosis in infancy will disappear. The time at which primary infection will occur will be postponed. Deaths will occur in the older age groups, the sixth and seventh decades.

The author feels that tuberculosis

will rapidly become a true social disease and that people living under good social and economic conditions will almost never die of this disease. He states that as the disease declines in incidence there will be less and less need for specific immunization procedures and more need for specific therapy. He feels that the mass x-ray methods now employed for various groups of society are of educational value, but in many surveys the actual number of cases turned up is small. He reports that Dr. Herbert Edwards has arranged for mass surveys in specific social groups where they have proved to be of greater benefit. Some of these groups would be:

1. Older age groups living under substandard conditions.

2. Negro populations living in congested conditions.

3. Industrial workers subjected to toxic dust.

4. Groups subjected to continuous exposure to the disease.

WILL PLAY MINOR ROLE

The x-ray method can also be applied to advantage to patients being admitted to the general hospital. The author feels that tuberculosis will, in a relatively short time, play a minor rôle in human illness, and that it will soon become an integral part of the over-all community plan for adequate medical service. Instead of treating it as a disease only, tuberculosis will be treated in all of its aspects, from prevention through rehabilitation.—IRVING GOTSEGEN, Montefiore Hospital, Country Sanatorium, Bedford Hills, N.Y.

About People

Administrators

Donald C. Carner, assistant administrator of North Western Hospital, Minneapolis, has been appointed superintendent of the Parkview Memorial Hospital which will be constructed at Fort Wayne, Ind., by the Methodist hospital board. The board recently completed a fund-raising campaign for an entirely new hospital, which was over-subscribed by more than \$400,000. Mr. Carner is a graduate of the University of Chicago course in hospital administration.



D. C. Carner

Harold Baumgarten Jr. has resigned as administrator of Gooding Memorial Hospital, Gooding, Idaho, to accept the position of hospital relations director of Idaho Hospitals Service, the state's Blue Cross plan. He has been succeeded at Gooding by **David Campbell**, formerly administrator of Community Hospital, Council, Idaho.

John L. Beckwith has been appointed assistant administrator of Highland Hospital, Rochester, N.Y. Mr. Beckwith received his degree in hospital administration from the University of Minnesota and served his administrative residency at Syracuse Memorial Hospital, Syracuse, N.Y.



E. S. Van Wagenen

Edward S. Van Wagenen is the new superintendent of Lakeside Methodist Hospital, Rice Lake, Wis. Mr. Van Wagenen replaced **Dwight Hansen**, who resigned to direct the Lakeland Medical Center, Willmar, Minn.

Mrs. Nellie Geary, formerly administrator of Saratoga Hospital, Saratoga Springs, N.Y., is now administrator of Cyril and Julia C. Johnson Memorial Hospital, Stafford Springs, Conn.

Gladys A. Cooper has resigned as administrator of All Saints' Hospital, Philadelphia, effective July 15, to accept the

position of administrator of Woman's Hospital of Cleveland. Prior to becoming associated with All Saints' eight years ago, Miss Cooper was superintendent of American Oncologic Hospital, Philadelphia.

Robin C. Buerki Jr., assistant director at St. Luke's Hospital, New York City, has been named director of Valley Hospital, a general hospital now under construction at Ridgewood, N.J.

Dr. Roger B. Nelson has been appointed assistant director of the University Hospital, Ann Arbor, Mich., and will assume his duties on August 1. Since February 1947 Dr. Nelson has been on the administrative staff of the New York Hospital, first as executive assistant, and later as director of the outpatient department and assistant director. He is a personal member of the American Hospital Association.



Dr. Roger B. Nelson

Donald M. Cox, formerly secretary and manager of Winnipeg Municipal Hospitals, Winnipeg, Man., has accepted an appointment with the Hospital Insurance Service of British Columbia as assistant commissioner in charge of hospital services. Mr. Cox has been associated with Winnipeg Municipal Hospitals for the last 18 years and had served as secretary and manager since 1942. He is the immediate past president of the Upper Midwest Hospital Conference and vice president of the Manitoba Hospital Association. He has been succeeded as secretary-manager at Winnipeg Municipal Hospitals by **John M. McIntyre**, assistant secretary-manager for eight years.



Donald M. Cox



J. M. McIntyre

Ernest A. Ryberg has been appointed administrator of the Anna City Hospital, now nearing completion at Anna, Ill. Mr. Ryberg received his B.S.H.A. from Northwestern University in June. His year's administrative residency was divided between St. Luke's Hospital in Chicago and Sherman Hospital, Elgin, Ill.



E. A. Ryberg

Nelson Hedrick, formerly administrative intern at Lenox Hill Hospital, New York, and administrative assistant at Manhattan General Hospital, New York, has been appointed assistant superintendent of the Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, N.Y.

James C. Davie, administrator of Tallahassee Memorial Hospital, Tallahassee, Fla., for the last year, has resigned to return to his home in Petersburg, Va., where he will enter into the general practice of law. Mr. Davie will devote a considerable part of his time to financial and legal problems of hospitals.

William H. Thrasher has resigned as hospital field representative, division of hospital services, Georgia Department of Public Health, Atlanta, to accept the appointment of assistant director of John D. Archbold Memorial Hospital, Thomasville, Ga.

Robert M. Schnitzer succeeded **Charles Lee** as director of Lutheran Memorial Hospital of Newark, N.J., when the latter resigned on May 31. Mr. Schnitzer had been assistant administrator of the Hospital Center at Orange, N.J., for the last four years.

Dr. Frank P. Guidotti has been appointed medical director of the new health center that the Hotel Association of New York City and the New York Hotel Trades Council, A.F.L., will soon open in New York City. Free medical service will be given at the center to 35,000 members of hotel employee unions affiliated with the council. Dr. (Continued on Page 164.)

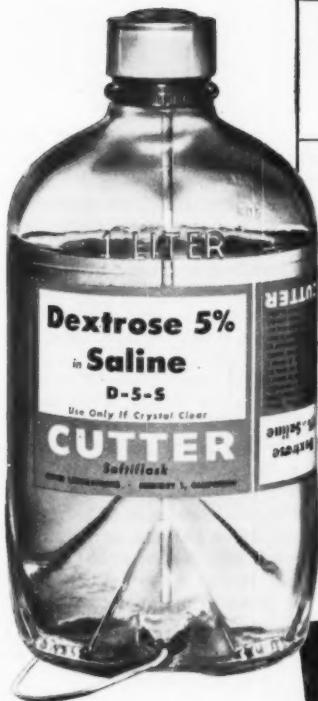
You make the comparison

Use this handy check chart of Cutter Safti-System Advantages

Check this column

Features of Cutter Saftiflask Solutions Line

1	"GOLD" SAFTISEAL CAP	✓	
	a. Metal cap protected from corrosion	✓	
	b. Easy to open-pull-tab big as a quarter	✓	
	c. Reduces possibility of torn fingernails and cut hands	✓	
2	EACH SAFTIFLASK IS NEW	✓	
	a. Bottle is made of special glass	✓	
	b. Meets rigid U.S.P. specifications	✓	
	c. Non-returnable feature saves labor and storage space	✓	
	d. Assurance of mechanical perfection of new equipment	✓	
3	EASY-TO-READ LABEL	✓	
	a. Easily read upside down or right side up	✓	
	b. Reduces possibility of error	✓	
	c. Saves time in solution identification	✓	
4	POP-UP BAIL	✓	
	a. Automatically pops-up when bottle is lifted	✓	
	b. Holds Saftiflask securely—safely—in ice-tong grip	✓	
	c. Design of bail saves storage space	✓	
5	VACUUM SEALED	✓	
	a. Mechanically induced vacuum protects all solutions (Blood Bottles, too) in Saftiflasks		
6	COMPLETE LINE OF SOLUTIONS	✓	
	a. Full line of standard and special-purpose U. S. P. solutions		
7	OVER 100 HOSPITAL SUPPLIERS SERVE YOU	✓	
	a. Reduces necessity of large stock in your hospital	✓	
	b. Strategically located for emergency delivery		
8	NEW, MODERN SHIPPING CARTON	✓	
	a. Smaller, stronger, lighter carton saves storage space	✓	
	b. Carton label easy-to-read, identify		



CUTTER • Saftiflask Solutions

CUTTER LABORATORIES, BERKELEY, CALIFORNIA

Volunteer Forum

Conducted by Raymond P. Sloan

Doctors and hospitals, please note:

Only Cooperation Can Prevent Socialization

RONALD A. JYDSTRUP

Administrative Resident, Robert Packer Hospital
and Guthrie Clinic, Sayre, Pa.

THE American doctor and the voluntary hospital together are presently fighting a battle which, whether we recognize it or not, is being waged against odds that even some of our leading hospital administrators feel are too great to overcome. Let us look back and try to examine why.

First of all, we have been slow in recognizing that the basic philosophy of the American citizen is changing. He is now interested in security, primarily economic and social security. We have heard many of the leaders in the medical and hospital world stress such changing philosophy but we have been slow to recognize or have refused to recognize this change.

NO EXPLANATION OFFERED

Second, we are faced with increasing costs for both medical and hospital care, and, as yet, we have not given the public a logical explanation as to why hospital costs, especially, have increased. The taxpayer cannot recognize yet why hospital deficits are increasing when he believes he has been contributing more toward their support through taxes, Blue Cross and contributions. Coupled with increasing costs is the fact that the demand for medical and hospital care is increasing.

Third, we have not, as yet, with the exception of a few employer sponsored plans, offered the public a full coverage plan for both medical and hospital care. This premise cannot be overemphasized.

Finally, we are faced with the element of time. Time alone could be cited as the main reason we are fighting against odds which many feel are too great to overcome.

Let us now try to analyze our present status in relation to the foregoing premises. The public's interest in se-

curity hasn't been an overnight development. The tremendous growth of the voluntary insurance programs since their inception is evidence enough to prove this fact. But this growth has not occurred without opposition. Doctors are still trying to overcome the fact that at first many of them opposed any type of voluntary insurance and we must face the issue that the average citizen is well aware of it. Critics of our present voluntary system of insurance have used this evidence to their advantage. The present negotiations being carried on in industry for pension plans rather than wage increases, or a combination of the two, should be ample proof that the public is interested in security.

The doctor must recognize that prepaid medical care on a voluntary basis can only be extended to the extent that he recognizes physicians' services as a major part of the cost of the patient's care and that he cooperates with and fosters the extension of such medical care programs as Blue Shield. The voluntary hospital must recognize that Blue Cross payments are not only a source of income to the hospital but also a means by which the citizen is striving for security. Memberships in Blue Cross total some 37,000,000 and in Blue Shield, approximately 13,500,000. However, the greatest percentage increase in Blue Cross memberships has been in the first few years of its history rather than in the last few.

Blue Cross authorities believe that 75 per cent coverage of the nation's population is the critical minimum which we must achieve if we can be reasonably secure as to the future of voluntary insurance programs. To arrive at this minimum the doctors and the voluntary hospitals must do their

utmost to aid in selling these programs to the public or we will find ourselves far short of this minimum.

The problem of increasing costs of medical and hospital care as well as the increased demand for such care is one that is foremost in the public's eye. According to the *Survey of Current Business*, National Income Number, July 1948, total selected consumer expenditures in 1947 increased to 259 per cent of the base years of 1935-39 which were used as the average of 100. In this same period hospital patients' expenditures increased to 298 per cent in 1947 of the 1935-39 average, and payments to physicians increased in 1947 to 202 per cent of the 1935-39 average.

WE ARE GIVING BETTER CARE

It is recognized that the costs of rendering hospital and medical care have gone up in proportion but the patient is entitled to, and demands, an explanation for this increase in costs, especially of hospital care. Hospitals have been extremely lax and in many instances have not attempted an explanation. To win active support of the public we must present the case of increasing costs to it and present it in a manner it will understand. It is not enough to say that hospital and medical care costs have gone up just as the general cost of living has risen. We must explain that the public is getting more and better medical care than it has ever had and that to give this medical care, increased facilities must be added which in turn cost money.

The physician must aid the hospital in this explanation to the public; he must not forget that increasingly he is using hospital facilities for the diagnosis and care of the sick and that without these facilities he would

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not be able to render the present high standard of medical care that the patient is obtaining in our hospitals. The doctor and the voluntary hospital must cooperate in explaining to the public; neither one can do it alone. Until they do cooperate the problem of increasing costs of medical and hospital care will remain a formidable target for the proponents of a compulsory insurance system.

As yet the voluntary insurance systems, *i.e.* Blue Cross and Blue Shield, have not brought into use their strongest weapon. That weapon is a complete coverage program for medical and hospital care. We must remember that every dissatisfied Blue Cross and Blue Shield patient is a likely convert to a compulsory health insurance program. With increasing costs of medical and hospital care we recognize that the problem of a complete coverage program has presented obstacles that are difficult to overcome. Even though Blue Cross and Blue Shield subscribers usually recognize the value of their present coverage, one of their chief complaints is that the benefits are not extensive enough.

UNION OFFERS ENCOURAGEMENT

At the American Hospital Association convention in Cleveland, Blue Cross and Blue Shield received strong encouragement from Harry Becker of the U.A.W.-C.I.O. social security department. Mr. Becker's address stated that organized labor prefers Blue Cross and Blue Shield as the mediums for prepayment of hospital and medical care with, however, the sole condition that they offer a complete package available on a nationwide basis. He further stated it is possible for the average worker to budget for food, rent and clothing and other fairly fixed expenses, but that medical care because of its dynamic nature is not in this category. Mr. Becker's warning cannot be dismissed lightly.

Another argument the public has presented is that Blue Shield income limits restrict membership and defeat the purpose of the prepaid medical care plans. Blue Shield has recognized this argument as some plans have raised the income limits recently. However, the basic defect is still present, *i.e.* membership is still being restricted. Furthermore, Blue Cross and Blue Shield plans still fear the domination of one by the other. The plans themselves disagree as to what should be hospital services and what

should be medical services. Hospital plans which include x-ray coverage are charged with dominating medicine.

The statement has been made repeatedly that a fully comprehensive medical and hospital plan is not feasible. Here we are recognizing defeat emotionally. We still must face the facts and reality. We cannot admit defeat and say that such a comprehensive plan is not feasible; we thereby give the proponents of a compulsory insurance system their strongest argument. We must experiment with a complete coverage plan and such experimenting must begin soon.

The American doctor and the voluntary hospital must render all assistance possible in the development of a complete package for medical and hospital care. In rendering that assistance they must consider the medically indigent and the indigent. We must recognize that any comprehensive medical and hospital care plan which calls for the payment of premiums on prepaid voluntary insurance by the government for the medically indigent and indigent must involve rules and regulations pertaining to that segment of the population covered. No government, whether national, state or local, would agree to payments to Blue Cross and Blue Shield for insurance premiums unless rules and regulations were set up to ensure that the funds were expended properly and were accounted for in terms of quantity, quality and costs of medical and hospital care.

As we have said, the time element alone could be cited as the main reason we are fighting against odds which many feel are too great to overcome. In a survey conducted by The MODERN HOSPITAL, the results of which were published in the September 1949 issue, 12 questions were asked on major problems in the hospital field today. One of these questions was, "Will we get compulsory health insurance in the U.S.? When? It is good or bad? Why?" The 25 leading hospital administrators from all sections of the country who answered this question generally agreed that we will have compulsory health insurance within from two to 10 years and they generally agreed that it is a bad thing for the hospital field as a whole. In view of this we must examine our present methods of fighting the threat of compulsion. Senators and representatives who are critics of national or state medicine concur that to com-

bat the threat we must support counter measures, such as government encouragement of prepayment plans, and financial aid to hospitals, professional education, public health units and research, rather than condemn the proponents of compulsory insurance.

We must face reality and not let our emotions defeat us. We condemn the health insurance program which has been in effect in England since 1948 as being bad but on the other hand we say that even though it is bad, such a system won't work in this country. The only way we can prove to the American people that our present voluntary system is the best in the world is to let them know our basic problem, inform them of our progress to date (and we cannot be afraid to admit our mistakes) and enlist their aid in promoting and extending the voluntary system.

HOW WE VOTE IS IMPORTANT

We cannot accept the defeatist attitude that seems to have arisen in some quarters of the hospital field. We have to face the fact that how we vote in selecting our congressmen in the next two years will, more than any other factor, determine the type of program for medical and hospital care we will have. We have made definite progress in Congress as far as counter measures are concerned to combat the threat of compulsion. Last September the Senate passed a five-year \$280,000,000 program to aid in the production of doctors, dentists, nurses and technicians. The House of Representatives has passed a bill doubling the aid for hospital construction from \$75,000,000 to \$150,000,000, and the Senate is expected to pass a similar bill. This type of constructive action will do more toward retaining our present voluntary system of hospital and medical care than will any of the condemning tactics which have characterized our past methods.

The doctors and the hospitals must cooperate in promoting and extending the voluntary system of medical and hospital care. In doing so, they must recognize the taxpayer's desire for economic security; they must give the taxpayer a full explanation for the increasing costs of medical and hospital care, and they must cooperate in the development of a complete package of medical and hospital care for the patient. But we must recognize that we haven't much time.



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MODERN INHALATION THERAPY

I—Organization of Service

W. ALLEN CONROY, M.D.

Director
Department of Anesthesiology
St. Luke's Hospital
Chicago

NO DISCUSSION of inhalation therapy is valid without first emphasizing the rôle of its practitioners. The increase in new procedures for inhalation therapy has happily been paralleled by rapid development of the necessary technician personnel. New groups of inhalation therapists are beginning training programs for their members.

In many hospitals, the physicians of the anesthesiology service are teaching and supervising the inhalation therapist. The latter can no longer be just an orderly who moves equipment and tanks of oxygen. He must be instructed in the practical use of 10 to 15 different pieces of apparatus, and in the theoretical considerations of the whole field of inhalation therapy. With such a background, he will be of greater service, and will take greater pride in doing good work.

While this will require wage scales proper to skilled technicians, it will at the same time justify the charges currently being made to the patient. The patient will certainly benefit as the standards for therapists are raised.

The lack of skilled therapists in the past has helped foster the impression that the attending physician is the only one who knows the answers about inhalation therapy. This may be a logical view in certain special procedures, but it is often not true in regard to most uses of oxygen. Newly graduated interns with a sketchy theoretical knowledge should be willing to accept the help and even the advice of a skilled technician in any field. Then we would not hear of demands for 95 per cent oxygen in a tent, for helium oxygen from separate tanks,

or for tent oxygen in midwinter for a patient whose nursing care keeps him more outside than inside the canopy. Inasmuch as we cannot expect the change to come by itself, it is up to the therapist to "sell" himself and his skills to the physician. This cannot be done by a belligerent, know-it-all attitude, but by diplomacy and by enlisting the help of interested physicians in the cause of better inhalation therapy.

NUMBER OF PERSONNEL

It is impossible to supply good continuous inhalation therapy with only one technician. The smaller hospital may solve this difficulty in two ways: (a) by training one man on each shift from some other service, having him "on call" only for oxygen therapy, while he does his regular job, (b) by contracting with a commercial oxygen service to supply both equipment and personnel as needed.

The large hospital will need from three to five men for good service. As a starter, only one or two need be previously trained. We can move the best teaching therapist around to instruct untrained men. Medical students are often good candidates for the evening and night shifts. Women are usually unsuitable for the job, unless a husky man is available to assist with the heavier work.

A physician with adequate knowledge of the subject should be responsible for all inhalation therapy.

PHYSICAL LOCATION

The inhalation therapy service should have a definite headquarters in the physical plant, with a telephone, record system and storage space. It

should be handy to a truck-loading platform and to the elevators. No flammable materials should be stored in the same area because leaking oxygen feeds fires. The room itself must meet the standards of fire resistance set down by the National Board of Fire Underwriters.

BASIC EQUIPMENT

1. *Oxygen tents.* Minimum of two; must have cooling and air-circulating features, except for the open-top infant type. Tents with electrical refrigeration are the more expensive, but are real labor savers, inasmuch as no ice blocks or melted ice has to be handled. Ice costs in a couple of years might equal the difference of cost between the all-electrical and the wet-ice tent. Some tents use dry ice (CO_2 snow) for cooling and circulation. Dry ice may cause severe burns to the careless handler, but it is free of messiness, and the initial tent cost is low.

The canopy may be all clear plastic or opaque with windows. The former is more pleasing to the patient, but is less sturdy and costs more.

Tents should not be left on the wards when not in use but should be returned to the central location for storage and checkup.

The outstanding advantages of tents are air conditioning and a moderate oxygen concentration (40 to 60 per cent). The main disadvantages are their high cost and the great difficulty of achieving good nursing care concurrently with good oxygen therapy when the canopy is open too often.

2. *Oropharyngeal catheter.* Minimum of two sets; must have efficient water vaporizer to humidify the oxygen lest it dry out the throat. Sometimes referred to as nasal catheter oxygen, the method is ineffectual unless

This is the first section of Dr. Conroy's article on inhalation therapy. The second part will appear in the August issue of this magazine.

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the tip of the catheter is in the oropharynx, i.e. within full view at the back of the tongue. The catheter and its accessories are far cheaper than the tent, provide 40 to 60 per cent oxygen, and do not interfere with any type of nursing care. The outstanding disadvantage is that some patients do not tolerate the catheter well, especially children and irrational adults.

3. *Masks* are of two main types, and at least one of each should be available.

For simple inhalation, there are the B.L.B. and O.E.M. masks. These are available in both the full-face and the nasal variety. Few patients want to wear them for long, but they are most useful where high concentrations are needed (90 to 95 per cent). They are also convenient for intermittent self-application by the patient. They use much more oxygen than do tents or catheters, but their initial cost is moderate.

Positive pressure masks are similar to the others, except they must always be full-face and must have an escape valve adjustable to various inhalation pressures.

4. *Gas supply.* It is never economical to use small (D or E) cylinders for routine therapy; G and H sizes greatly reduce the cost of gases and labor. For institutions using large amounts, piping systems are often advisable because with them bulk oxygen or liquid oxygen may be employed, at great savings.

There is no need to insist on so-called "medical" oxygen. All oxygen available is purer than U.S.P. standards. "Medical" oxygen cylinders require different valve fitting from those of commercial oxygen tanks. Commercial oxygen valve fittings do not require sealing washers, and the cost is often lower.

Helium-oxygen mixtures should be kept available. Pure helium should

rarely be required. If helium and oxygen are given by the same mask from separate tanks, there is always danger that the helium will asphyxiate the patient if the oxygen tank becomes empty before the helium is exhausted. This cannot occur with the mixture of helium and from 20 per cent to 30 per cent oxygen.

CO_2 and CO_2 -oxygen (5 per cent CO_2) should be on hand, chiefly for their use in promoting breathing exercises in the postoperative patient.

5. *Resuscitative apparatus* of all types should be under the jurisdiction of the inhalation therapy service. "Iron lungs" push-pull resuscitators, spare suction pumps, and so on should all be included, both for storage and for servicing.

6. *Aerosol vaporizers* may be provided for penicillin inhalations.

A second article will discuss the rôle of inhalation therapy in hospital medicine today.

The responsibility of the MEDICAL CENTER

to the FAMILY PHYSICIAN

WHEREVER specialists in the various fields of medicine organize themselves into a group for the practice of medicine, whether it is in an office building, a hospital or a medical school, a medical center is established.

To fulfill its purpose, a medical center must be a complement to, not a competitor of, the family physician. For the great majority of patients, the family doctor is the sum total of necessity. In perhaps 15 per cent of illnesses more specialized care is needed. The medical center that will accept the responsibility for the care of those illnesses requiring specialized attention in a spirit of cooperation and teamwork with the family doctor is an agency which immeasurably improves the quality and availability of medical care throughout the entire area served.

In our organization, a group practice clinic whose staff is composed of the clinical faculty of the medical school which is associated with a 300 bed teaching hospital, we have found that a close interdependence exists be-

C. T. HARDY Jr.

Business Manager
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of Wake Forest College
Winston-Salem, N. C.

tween our staff and the doctors throughout the state by whom patients are referred to us.

A large part of our job is to render to these referring doctors a service that will be of real benefit to them and to their patients. If we do not render good service to them, we have failed not only ethically but in a business way. We can exist only as long as we are useful in providing good medical care.

With this realization of our responsibilities in mind, we decided some months ago to find out how we could best serve our referring doctors and wherein we failed in working with them.

Two hundred and fifty doctors in North Carolina, who had referred patients to us, were sent a letter and

questionnaire. The letter in part said, "This . . . is sent to you . . . because we are interested in improving the services which it may be possible for us to render to you and the patients referred to members of our staff by you.

" . . . A medical center is most useful in the treatment of patients only if its staff members consider themselves as a part of the team which consists of the referring physicians throughout the state and themselves.

" . . . Our chief function is that of diagnosis.

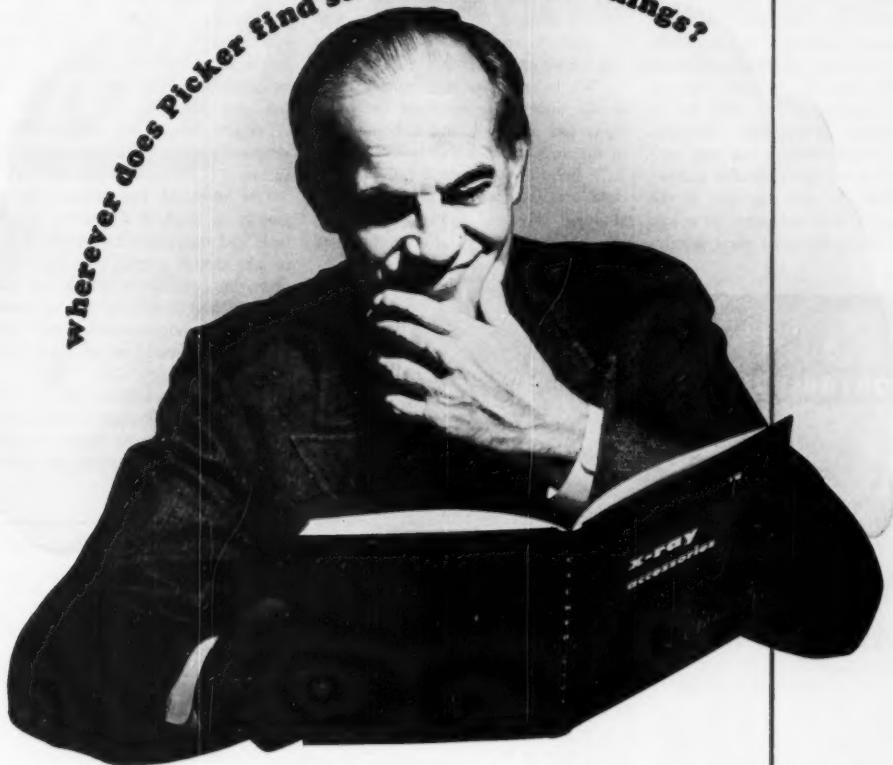
"Will you take time to fill out the attached sheet and return it to us in the enclosed envelope? . . .

"We sincerely hope that the results of this study will enable us to improve the care of patients."

Attached to this letter was a questionnaire, the text of which is given with the answers farther along in this paper.

The results were surprisingly good. We received 128 completed questionnaires.

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After the individual answers had been tabulated, we wrote again to the doctors who had received the questionnaires, giving them the results of the study. This reply was not limited to those who had answered the questionnaires, but was sent to the entire group. It was felt that the answers were of sufficient interest to be seen by as large a group as possible. Excerpts from the letter which was sent and the results of the questionnaire follow:

"We feel that the response to the questionnaire sent out some time ago from our clinic has been most gratify-

ing. It has been a truly inspiring study. We are proud of the nice things said about us, and honestly concerned about the criticism. You may be assured that every effort will be made to correct those things that are within our control.

"We believe you will be interested in the answers to some of the questions and are enclosing a breakdown of the answers with this letter.

"I believe the most common criticism was that our reports go out too slowly. We are working on plans which I believe will almost eliminate

this criticism. We expect to have a new system in effect within the next few weeks.

"A meeting will be held of our staff and the comments in the questionnaire will be taken up, one by one. We hope that many causes for dissatisfaction can be eliminated as a result of your constructive criticism.

"A schedule of our charges will be prepared and mailed to you in the near future.

"As most of you realize, we are greatly in need of additional hospital beds and outpatient facilities. We try to take care of emergencies and urgent cases, but sometimes we do not even have a bed available for an emergency. We hope someday, of course, to be able to build an addition to the hospital.

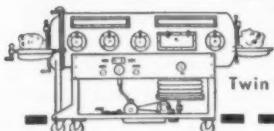
"Again may we thank you for your cooperation. We hope from time to time you will let us know anything that we can do to improve our service to you."



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Answers to Questionnaire

1. Do you refer patients to our clinic or to any other medical center primarily because of the reputation of individual staff members or because of the reputation of the institution?

ANSWERS:

(1) Reputation of individual staff men	41
(2) Reputation of institution	25
(3) Both	36
(4) Both, but primarily individual	12
(5) Both, but primarily institution	4
(6) No answer	10

128

2. How do you want the patients referred by you to our clinic or another clinic handled?

(a) Do you want them seen purely for diagnosis?

ANSWERS:

(1) Yes	40
(2) No	40
(3) Usually yes	23
(4) Usually no	3
(5) Indefinite answer	22

128

Note: Analysis of the "No" answer:

(1) Judging by other answers, really prefer to have them sent home for treatment unless specialized care is needed. 35

(2) Really prefer to have treatment done in medical center by specialist. 5

40

Comment: Obviously most of our referring doctors prefer to treat their patients at home unless specialized treatment is required.

(b) Do you want us to outline treatment for the patient?

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ANSWERS:	
(1) Yes	110
(2) No	3
(3) Only when specified or necessary	5
(4) No answer	10
	—

(c) Do you prefer that treatment be done here?

ANSWERS:	
(1) Yes	8
(2) No	20
(3) When best for patient	23
(4) Only for specialized conditions	57
(5) Only for emergency	4
(6) Only when requested by doctor	9
(7) No answer	7
	—

128 3. What do you want included in the reports sent to you by our staff men?

128

(d) How do you think we should handle a condition requiring surgical correction which is found during the course of examination?

ANSWERS:	
(1) Send back to or contact referring doctor for decision	38
(2) Operate here unless otherwise directed	26
(3) Respect wishes of patient	31
(4) Use our judgment	10
(5) Operate here for specialized cases only	17
(6) Send home for operation	4
(7) No answer	2
	—

128 3. What do you want included in the reports sent to you by our staff men?

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ANSWERS:
(1) Physical findings
(2) Special studies
(3) Diagnosis
(4) Suggested therapy
(5) Copy of pathology report, if any
(6) Copy of operative report, if any
Note: It is noteworthy that the family doctors are not interested in having a history reported by the specialist.

4. Have you received complete and prompt reports on patients referred to our doctors?

ANSWERS:	
(1) Yes	84
(2) No	29
(3) Not always	15
	—

(a) If not, we would appreciate as specific criticism as possible so that we might correct this.

ANSWERS:	
(1) Slow	34
(2) Never received	2
(3) Some slow, some not received	5
(4) No comment	3
	—

Comment: The criticism was not for incompleteness of reports, but of the delay in getting them. As mentioned, steps are being taken to correct this.

5. Have you ever been alienated from a patient as a result of referring him to this or any other medical center?

ANSWERS:	
(1) Yes	30
(2) No	76
(3) From other medical centers only	19
(4) No answer	3
	—

Comment: There was a distressingly large number of affirmative answers to this question. This point will be emphasized with our staff and we shall make every effort to avoid contributing to this alienation. A number of those answering "Yes" pointed out that this was unavoidable in some cases, and that the reasons for this lay with the patients rather than the medical centers.

6. How do you think your patients are handled financially?

(a) Do you think they are overcharged or undercharged?

ANSWERS:	
(1) Overcharged	18
(2) Undercharged	2
(3) About right	59
(4) Don't know	36
(5) Sometimes over; sometimes under	5
(6) No answer	8
	—

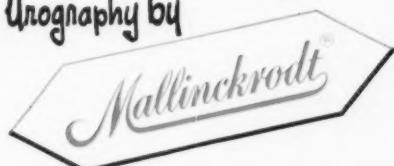
128
(b) Are they sometimes seen in the charity clinic when they should come through the private clinic or vice versa?

ANSWERS:	
(1) Charity clinic, through error	11
(2) Private clinic, through error	2
(3) Yes, both ways	37
(4) Don't know	8
(5) No	59
(6) No answer	11
	—

128



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Comment: It is difficult to say how much improvement we can make in this situation at present. We attempt to screen the patients before appointments are given, by mail or by interview, but errors are often made. After a patient arrives from a distance to fill an appointment either in the out-patient department or in the private clinic, it is difficult to switch him from one department to another because all appointments are filled. Frequently, in an effort to avoid creating a hardship for the patient, we go ahead and see the patient even though we realize he is in the wrong clinic. We always appreciate the help we get from you in determining a patient's financial status before an appointment or reservation is made.

(c) Do you feel that you should know more about our financial classification of patients and fees charged?

ANSWERS:

(1) Yes	99
(2) No	29

128

Comment: As stated in the letter this will be prepared and mailed to you at a later date.

7. Are your patients pleased or dissatisfied with their treatment here?

ANSWERS:

(1) Pleased	89
(2) Most are pleased	31
(3) Some are dissatisfied	7
(4) No answer	1

—

8. Are you pleased or dissatisfied with our treatment of your patients?

ANSWERS:

(1) Pleased	108
(2) Dissatisfied	3
(3) Generally pleased	14
(4) Sometimes dissatisfied	3

—

128

Following this, a memorandum was prepared for presentation to the staff of the Private Diagnostic Clinic. In part, these comments were made to the group.

"We must bear in mind while studying the results of the questionnaire that the doctors queried were a selected group in that they do refer patients to us. This means that we have asked our friends what they thought about us and we must avoid complacency over the favorable tone of the answers.

"They were not all 100 per cent satisfied customers, however, and I believe we should study the answers carefully and make every effort to correct the criticized things which are within our control.

"We must take great care to avoid criticizing the referring doctor to the patient. It is much too easy, living in the rarified atmosphere of a medical school, to be somewhat contemptuous of the way medicine is practiced in the rural districts. It might be both

humbling and enlightening to remove the 'props' from about us and see if we could do better. The fact that the family doctor referred the patient to you shows that he recognizes your superior training and ability or the superiority of the equipment with which you work. Don't try to make yourself important at his expense. The patient must be dependent on the family doctor for his routine care and if you destroy his faith in his doctor, you have not done anyone a favor.

"There were a good many nice things said about our clinics and this questionnaire. Those who filled out the questionnaire seemed to feel that it showed an honest desire on our part to give them better service.

"Some of the more constructive criticisms were:

1. If a report is to be delayed, tell the patient so that he will not report back to the referring doctor too early.

2. Send to the referring doctor a complete list of the staff members and their specialties at regular intervals.

3. If a patient is referred to our clinic by a specialist, also get the name of the family doctor and send him a copy of the report.

4. Remember how much trouble and expense are involved for a patient to travel back and forth long distances to the clinic. Hold down return visits to a minimum.

"Judging the questionnaire as a whole, most of the referring doctors are pleased and feel that we are doing a good job. They don't want anything unreasonable. They do want their patients seen as soon as possible and emergencies taken care of immediately. They want to be notified before we proceed with treatment or operation. They want prompt and complete reports. They don't want us to tell their patients that they have been treated incompetently, and they would like to have their patients returned to them in as good condition as possible.

"It is hoped that this survey will enable us to do a better job in the future."

It is felt by our group that this entire study has had a healthy effect on us and on our referring doctors who feel now that we are interested in their point of view. We have noticed an increase in "constructive criticism" from these doctors. It is our hope that we may be able to maintain this spirit of cooperation and mutual endeavor on its present high plane by a constant reevaluation of our work.



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Division of The Kendall Company, Chicago 16

Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

How **MIRACLE DRUGS** are born

AT ONE time new drugs were found by accidental discoveries of their peculiar effects in man. Thus:

Quinine was discovered because a cinchona tree fell into a pond near an Indian village and a brave too sick to travel farther for better water drank the bitter water and got well.

Ergot was discovered because tainted rye produced abortion in the poorer classes that could not afford better flour for their bread.

Digitalis was discovered because an early physician listened to an old woman's tale of a treatment for dropsy.

Atropine was discovered by a pharmacist's apprentice named Daries who rubbed his eye while filling a prescription.

Strophanthus was discovered because the botanist on Livingston's expedition to Africa kept his toothbrush in the same pocket with some poisoned arrows.

Epsom salt was discovered by a farmer who had a spring on his property from which his cattle refused to drink. He drank and the pharmacological effects were promptly called to his attention.

Veratrum, which has a strong parasympathetic stimulant effect, was discovered by the shepherd boy Melampe who noted that his sheep developed violent diarrhea after eating the plant called hellebore.

Acetanilid was discovered accidentally by one of Professor Kussmaul's assistants who took the compound and noted a drop in his body temperature—undoubtedly with some degree of cyanosis.

Epinephrine was discovered because Oliver made extracts of various tissues of the human body and injected them subcutaneously into his own son. He

discovered that an extract of the adrenal gland was the only tissue extract which accelerated and hardened his son's pulse.

Such rash human experimentation is at best futile and at worst fatal. The Nazi physicians under Hitler's orders tried many human experiments. The mortality was high and the scientific knowledge almost nil.

Fortunately, since the turn of the century, most new drugs have been newly-made chemically and carefully tested in experimental animals. When the chemist succeeds in making a new chemical, that is exactly what he has, *only a new chemical*. Then this chemical is turned over to the pharmacologist and its effect is determined in animals. If the drug action is of interest, then various species of animals are used to determine if *all* animals are affected in the same way. The mouse, rat, guinea pig, cat, dog, and monkey may be used to prove that the drug has predominantly the same effect in all of these species and hence may have that effect and *no other toxic action in man*.

A chemical thus becomes a drug only when and if someone discovers that it has an action which will help or cure disease. In other words, the drug must be tested in living animals.

The Early and Only Vivisectors

If we go back to the Nineteenth Century, we find that much of our early physiological and pharmacological knowledge was gained by operations on living, unanesthetized animals. Claude Bernard (1813-78) and his predecessor Francois Magendie (1783-1855) made numerous studies on unanesthetized animals, but then one must remember that anesthesia

was not discovered until 1846 and that prior to this discovery all surgical operations in man were done with the aid of strong assistants to hold the pain-racked patients on the operating table. One must also recall that anesthetic drugs were discovered in man and hence the study of these agents in animals took many years before the experimenter could be certain that these pain-killing drugs would not invalidate the experiments. Such data were accumulated by 1900 so that in the Twentieth Century all experiments in animals can now be conducted without pain to the experimental animal.

Birth of the Antivivisectionists

In the Nineteenth Century, French veterinarians reacted to these painful experiments in animals and were instrumental in organizing the antivivisectionists in Europe. This occurred almost at the same time that medical scientists were learning enough about anesthetics to use anesthesia in all experiments. However, in spite of improvement in animal care and experimentation the antivivisectionists are still with us and represent a vociferous and well organized 3 per cent of the voting population. In contrast to this small minority group, a recent opinion survey showed that 85 per cent of the voters are in favor of turning over to medical, veterinary and dental research and teaching all unwanted, unclaimed stray dogs and cats.

What Perpetuates the Antivivisectionists?

Vivisection is gone, but a few antivivisectionists are still with us! Undoubtedly three factors are involved in the self-perpetuation of the antivivisectionist. The first and most important is *ignorance*. Ignorance of biological science is common in this sect of crackpots. Some do not believe in vaccination, the use of insulin or eating meat, but they do wear furs, feathers in their hats, and leather shoes. One stated that rabies in dogs is not a disease but is merely a series of symptoms which result from repeated mistreatment of the dog. One stated that the Nazis, without animal experimentation, were able to make human blood out of stone. Yet another recently stated in Baltimore that the use of penicillin was the greatest cause of postoperative mortality in any operation. Yet another stated that medical scientists should learn as do the



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astrologists by observation instead of experimentation! And the final insult to our intelligence came from an editor who said we should make a mechanical man and test our drugs on him! This to scientists who have not been able to make even a one-celled form of life. The machines of I.B.M., G.E., or M.I.T. do not compare with the lowest form of life made by God!

Avarice the Second Factor

Business enterprise such as motivates the confidence man may also motivate the antivivisectionist. Public relations experts have been known to discover that a neater and quicker buck can be made by playing upon the heart strings of a gullible public. Thus, a new antivivisection society can be formed in any state or municipality, donations can be solicited and contributions will roll in "to help prevent pet torture." The public loses because medical progress is hindered and the only winner is the secretary or managing director who, with little effort, draws his pay for his organizational and soliciting efforts. Avarice may also be a major factor in the numerous theatrical characters who see and use the antivivisectionist movement as a means of continued publicity when their theatrical careers are over. A few newspapers will allot extensive space to these publicity seekers.

Misplaced Sympathy Is the Third Factor

Medical scientists are not sadists or torturers. They are more interested in truly humane movements and the prevention of cruelty to animals than any other group. They are the discoverers of various anesthetics which are routinely used by veterinarians to ease pain in animals and occasionally to provide a painless death for over-age or injured pets. They, however, consider human life and well-being above that of animals, while many antivivisectionists consider the dog or the cat to be more important than children and human life. One antivivisectionist points out that dog spelled backwards reads God and infers that the canine race is thus superior to man, woman and child, which are meaningless when spelled backwards. The scientific discoveries of medical scientists have increased man's expected life span from 47 to 67 years since 1900 and, while the statistics are not available, the scientists' efforts have undoubtedly increased the useful life span of our pets and domestic animals, also. And

yet, the Pitman-Moore Company in Indianapolis has difficulty in obtaining enough unwanted, unclaimed, stray mongrel dogs to make rabies and distemper vaccines and serums to protect and save the lives of our pedigreed pets!

Laws Require Experimentation

The United States Pharmacopeia requires that 52 drugs be assayed in animals before they are sold for use in man. The Food and Drug Administration acting under authority of the 1938 Food, Drug, and Cosmetic Act requires elaborate animal testing before any new drug can be marketed. Thus, a chemical may be studied from one to five or more years in animals before the conditions for use in man are determined. But even this warranted delay does not compare with the many years that may elapse before a new chemical is tested in living animals and its drug effect discovered.

Thus, Gelmo in 1908 made the first sulfa drug, but it was merely a chemical. The world unwittingly awaited the animal experiments of Domagk when in 1932 he used a sulfa drug to treat mice made sick with virulent germs. The mice did not die and by 1937 the drug sulfanilamide had passed all animal tests and could be cautiously tried in human bacterial infections. The results were nothing less than miraculous. The hemolytic streptococcus is one of the most dangerous of germs. When it caused blood poisoning, previously about three out of four of its victims died. In childbed fever, the toll was approximately one in four, while streptococcal (spinal) meningitis was invariably fatal. All this was now changed. Consider, in retrospect, how many thousands of lives would have been saved if Gelmo, in 1908, had only tried (or had Ehrlich try) his chemical on a few sick mice!

Antihistamines

As a further example of how important drugs are discovered we can cite the example of drugs which counteract histamine. Histamine is ordinarily combined in a harmless inactive form in the body, but when animals or men become sensitized to pollen or dusts, this allergy or sensitization results in the sudden release of histamine in potent form so that the human being or animal is then subject to all of the actions of histamine which may cause asthma, hives, swelling of the tissues, sour stomach, cramps, head-



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ache, fainting, or a persistent and troublesome skin rash.

The scientist has shown by the following tests that this new chemical will counteract histamine. (1) He used the isolated bowel of the guinea pig in a constant temperature bath to show that spasm or cramping induced by histamine could be prevented. (2) He placed groups of treated and untreated guinea pigs in a glass enclosed chamber and allowed a measured amount of histamine mist to be forced into this chamber. The untreated pigs died of asthmatic constriction of their bronchial tubes while the pigs injected with the new chemical remained miraculously unaffected. (3) Knowing that histamine will produce fainting owing to a sudden drop in blood pressure, he further used several anesthetized dogs or cats to see first of all how much drop in blood pressure a standard dose of histamine would produce and second if this reduction could be prevented by the new chemical. In addition, the scientist used all of the known antidotes to histamine, such as adrenalin, ephedrine and aminophyllin, to see if this new chem-

ical was as good as, or better than, the marketed drugs.

Yes, this new chemical was better than these other drugs. Well you say, "Let's try it in patients." No, my friends, not so fast! In spite of all this work, we still have merely a chemical—a promising chemical, I grant you—but not a drug which is ready to use in man. The 1938 Food and Drug Laws were designed to protect mankind against promising brain-children of this type. Well, you say, "What's the delay?" We have 10 per cent of the population with allergic conditions, some of whom may not respond well to ephedrine, and this new chemical is effective orally so that they won't have to be injected with adrenalin. This new chemical antidotes histamine and has no serious side effects in your animals. The delay, my friends, may amount to one or two years while we feed this chemical to the dog, inject it into the growing rat and mouse, and perhaps even invest \$350 to purchase 10 monkeys to see if they lose weight, become anemic, have a serious drop in their white blood cell count, or have any serious damage to the liver or kidneys when injected or fed the chemical for a period of many months.

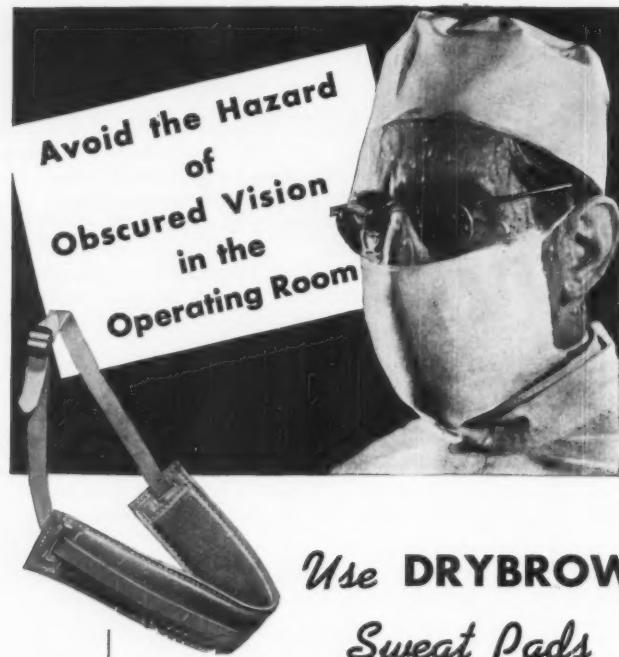
At least, you say, we can save money by using these monkeys and dogs over again for another drug if they have no alarming symptoms. I see you have naively forgotten the tissue studies. Microscopic examination of all tissues is essential, which means that the animals are painlessly sacrificed and studied microscopically. In addition, the drug application must include 400 clinical cases which show the effect of this new chemical in man. Only then can we start selling the drug for use by the physician and he must be trained carefully in how to use it. In summary you should realize that:

1. The Anticruelty Society of Chicago collects 23,900 dogs and 19,100 cats per year (10 year average) but finds homes for only 3.6 per cent of the dogs and 0.6 per cent of the cats. The rest die in a "euthanasia chamber."

2. If medical schools attempted to raise their own dogs these would cost more than \$75 each.

3. By killing 50,000 dogs per year the misguided "humane" organizations in the Chicago area destroyed a potential \$5,750,000 citizens' contribution to the heart, cancer and infantile paralysis drives.

4. For many experiments omnivor-



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ous dogs are better for medical research than are herbivorous monkeys.

5. The intestinal flora of the dog's intestines are more closely allied to man than are those of any other experimental animal. Thus sulfa drugs and antibiotics must be tested in the dog to determine their sterilizing effect for peritonitis and bowel surgery.

6. Pregnant dogs were used to show that the anticoagulant "dicoumarol" may produce fatal fetal hemorrhage if used late in human pregnancy to control abnormal blood clots.

7. Pregnant dogs might show the

cause of dietary blindness of premature infants. Which would you prefer? A few blind puppies or more blind babies?

8. In modern times all new anesthetic drugs are first tested in laboratory dogs, and the laboratory dog whether used in teaching or research is anesthetized before surgery and is not "cut up alive."

9. In England, laboratories are licensed to use cats and dogs in medical research. Germany, under Hitler, outlawed the use of the cat and dog and used minority groups of human

beings instead. The Nazi results were at best *futile* and at worst *fatal*!

10. The blue baby operation and all cardiovascular surgery has been perfected in the dog. Surgery residents learn these operations by practice on the citizens' unwanted stray dogs.

11. Most of our knowledge of the functions of the brain has been accumulated by research on cats.

12. Our pedigreed dogs, mink and all of our domestic animals have their nutritional and infectious diseases cured by knowledge gained in experimental studies on mongrel dogs.

13. The only animal counterpart of *pellagra* in man is *black tongue* of dogs, which resulted in the discovery of a cure of both these diseases, namely, nicotinic acid (niacin).

14. The K-9 Corps during the war consisted of pedigreed dogs performing tasks too dangerous for man, which tasks are now done valiantly and painlessly by mongrel dogs in the medical laboratory.

15. Federal law rightfully requires that scientists assay both parathyroid hormone and adrenalin in the anesthetized dog before their use in man.

16. Only a vociferous 3 per cent of the population is against animal experimentation, while 85 per cent is in favor of turning unclaimed pound dogs over to the medical schools and research laboratories.

17. The cause of diabetes and its treatment was first discovered in the dog.

18. Bleached white flour was proved by medical scientists to be poisonous for the dog, and the milling industry has voluntarily substituted a nontoxic agent.

19. The anesthetized dog is used to train physicians in the use of instruments to remove trinkets from children's windpipes.

20. Digitalis and other potent heart drugs are assayed in the cat.

21. The unwanted cat has supplied us with our modern anti-epilepsy drugs and our knowledge of the electrical activity of the brain.

22. Many unwanted dogs are used to make distemper vaccine and serum to prevent and treat distemper in pedigreed dogs.

23. Hookworm infests both man and dog so that new remedies for this infestation are first tested in the dog.

24. Almost all that is known about the stomach, intestine, liver and adrenal gland was learned by use of the dog.—C. C. PFEIFFER, PH.D., M.D.

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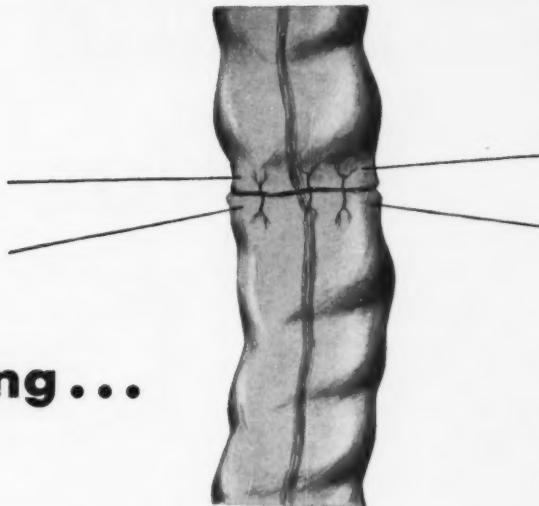
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UNTIL a few years ago the dining tables and trays of hospitals were set with "china," "silver," "glass" and, in many cases, "linen." Selections in these classifications depended on the type of service and the money available. The simpler and less expensive the service, the heavier the china and glass and the lighter the blank and the thinner the plating of silver. Only fine services furnished linen which carried any fibers of flax.

In moderate or low cost food services the results were usually far from attractive. They furnished no pleasing background which would make food appear appetizing or add to the pleasure of the patients or personnel. Nor were many of these items practical and economical. The weight and bulk of the heavy glass and china increased storage space, handling and breakage. The plated ware required frequent polishing to present a good appearance and the lighter plating "wore off" after a relatively short period of time leaving shabby, unattractive knives, forks and spoons. Frequent replating was essential to maintain the good appearance required in food services having high standards.

BETTER TABLEWARE AVAILABLE

Developments in all of these categories, most of them recent or currently underway, make it possible to select tableware for 1950 which is likely to be more suitable and satisfactory for each type of service than was formerly possible.

New shapes and designs in china and many beautiful new patterns on white, ivory or colored bodies offer a wide variety of choice for fine food service. The lighter weights are frequently selected, especially for items such as cups which are handled by the guest. These may prove as durable as the heavier weights, if institutions that

select this type of ware have careful employees and good supervision.

Attractive china adds much to the charm of the meal in hospital guest dining rooms where charges are set to cover costs of purchase and replacement, in private patient food service (especially if dishes are washed in the floor kitchen rather than being handled in a central unit), and in service for formal occasions.

Fortunately for hospitals which formerly found it necessary to purchase the less attractive china, the new plastic tablewares offer many desirable features. These wares, molded by some half dozen companies, are made of the melamine resins with fillers of alpha cellulose or cut fabrics and coloring agents. Light picnic wares, suitable also for some casual household uses, are made of polystyrene and of area formaldehyde; these are not recommended for heavy duty use.

The plastic wares, if properly molded with high polished chromium-plated steel dies, have a smooth finish. This surface can be dented by sharp knives but hospital food services do not feature steaks and chops frequently. Plastics come in several pleasing colors, are but one-half to one-third the weight of the vitrified china commonly used in hospitals, and cost approximately the same as that china although certain items may be slightly more expensive. Breakage is remarkably low so that replacement costs are negligible. Sanitation reports show low bacterial counts; in fact, some experiments have failed to develop bacterial growths on plastic.

Although little imagination has been shown in the design of these materials which need not conform to stereotyped

china shapes, some of the designs are pleasing and most of them possess certain practical features, such as saucers which prevent cups from slipping and also fit the top of the cup to prevent spillage while being carried on trays and to retain heat.

Plastics should not be subjected to dry heat above 200° F. or to autoclaving. They do not dry readily. The rinse temperature should be at least 180° F. and the presence of a small amount of wetting agent in the rinse facilitates drying without spotting.

CANNOT PREVENT STAINING

Although all molders are working to improve manufacturing processes they are as yet unable to prevent the staining of cups from tea and coffee. The stains are easily removed or prevented by use of the newer detergents of the oxygen liberating type, however, by short soaking in a solution of sodium perborate and a standard type of detergent.

Lightness and ease of handling, noise reduction, space-saving stacking, and low breakage make these wares particularly useful in hospital food service for patients and personnel.

Other wares appear on the 1950 trays or tables or on cafeteria counters and some are disposable. Paper items are used for service of certain foods, such as dressings, cream, sugar and fruit juices. Some paper containers may be used for casserole dishes and custard cups since they will stand oven temperatures required for cooking these foods. Such dishes in cooking china or glass usually require soaking before washing, so discardable items may reduce labor. Although the old oaken bucket is still seen on some of these containers several more attractive designs are now available.

Disposable, single service dishes have wide use for service to patients with



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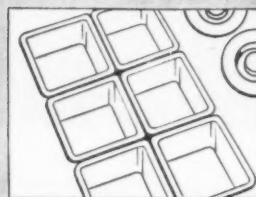
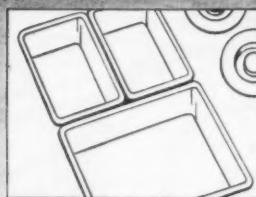
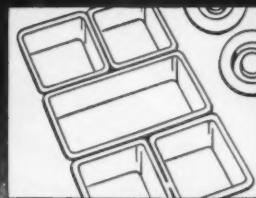
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infectious diseases, and in some children's services. Plastic, in one of several colors, is used by one manufacturer to cover the top surface of paper plates, thus improving appearance and preventing absorption of liquids and grease. Another manufacturer uses plastic in any desired color to impregnate paper plates and mess trays. These dishes will resist heat to 350° F. They are rigid and attractive and can be produced at reasonable cost in large quantity.

Nylon is another of the new materials now used for dishes suitable for some specialized hospitals. It is somewhat soft but almost indestructible.

RESISTANT TO BREAKAGE

Glass dessert dishes of new and pleasing design add much to the appearance of tables, serving counters and trays. Blown tumblers, heat treated, and so resistant to breakage that they almost seem to bounce when dropped, have now largely replaced the old style, heavy pressed tumblers.

Glass has come into the tableware field with other heavy duty dishes. In general it has the same disadvantages as heavy china and, except for certain items such as salad and sandwich plates, is not likely to be used extensively in hospital service.

Silverware has remained relatively unchanged in design though new patterns are available. For fine food services using fine china—unless the design is strikingly modern—beautiful silver furnishes a handsome addition to the tray or table. The silverware selected should be of a quality that will retain its attractive appearance. This means that blanks should be heavy and plating should be of full, hotel weight. It should be kept burnished and in excellent condition.

Stainless steel flatware is now widely used in services on which the cheaper plated ware was formerly purchased. It retains its original appearance—slightly darker than silver but not unattractive—does not tarnish, is easily cleaned with any good detergent and, if of heavy duty design, is sturdy and retains its shape.

Designs are limited, possibly because hardness of the material makes fabrication difficult. Another factor may be that most of this ware is at present manufactured by silverware companies and incentives to improvement have been minimized. There is particular need for more suitable flatware, especially for trays. Stainless

steel offers great opportunity for development of new, pleasing, modern designs which would feature more functional and possibly smaller items. Some attractive designs in stainless steel hollowware are already available. This type of ware is adapted to use with plastic dishes in modern design.

Tables also have a new 1950 look. Gone from many institutions are the acres of lanky white cloth which used to fill staff dining rooms. Tables with plastic tops in neutral tones or colors are widely used. Some of these tops include decorative mats selected by the institution. In many other dining rooms beautiful, gayly colored table cloths enhance the decorative scheme of the room. The cloths may be of solid color or with printed design. Colors are vat-dyed and fast. Weaves are interesting; the momie weave is one of the most popular. Cloths are usually cotton but where especial care

can be given to laundering them, cloths combining cotton and rayon are used. Napkins are made to match the cloths. Paper napkins are now used in many situations.

Trays are equally attractive. Most trays are of plastics filled with rags or pulp. They now come in pleasing colors and are selected for size in relation to the dishes to be used. Tray covers are of paper in pleasing patterns or of the same attractive colored or printed cottons as are used in table cloths. They are chosen to match or harmonize with the dishes. Napkins are made to match all designs.

Food in 1950, therefore, may be served more attractively and, frequently, more economically than heretofore. In view of the extensive research now in progress with old and new materials there is reason to expect interesting developments in all types of tableware during this coming year.

FOOD FOR THOUGHT

More Protein for Breakfast

Something new can be added to the popular slogan, "Eat a good breakfast to start a good day." The addition is, "and put in some protein-rich foods."

Comparing eight kinds of American breakfasts, scientists in the U.S. Department of Agriculture have obtained evidence that breakfast featuring protein-rich food, such as milk and eggs, can do more for the eater's sense of well-being and stave off fatigue hours longer than can a morning meal with less protein. Dr. Elsa Orent-Keiles and Lois F. Hallman, nutrition chemists in the Bureau of Human Nutrition and Home Economics, served meals for test periods to nine laboratory workers. In the two-year study, breakfasts put to test ranged from a cup of black coffee to a hearty meal that included eggs and bacon.

Those in the experiment consistently reported a sense of well-being when breakfast contained the larger amounts of protein. Their feelings agreed with the record of their blood sugar level—physiological indicator of the body's response to different meals, used in the study. The favorable feeling of well-being seemed to depend more on the amount and quality of protein

in a breakfast than it did on the calories from starch, sugar or fat. Influence of a breakfast with plenty of protein lasted even into the afternoon, when the workers ate a light lunch of a sandwich and coffee. "It begins to appear that the nutritional effectiveness of foods depends to some extent upon the way they are distributed in the day's meals."

It is an advantage to provide about a third of the day's protein allowance in breakfast, and to have some top-quality protein in this meal, such as milk, eggs and lean meats.

The National Research Council's yardstick for good nutrition provides for protein on the scale of 60 grams daily for an average-sized woman, 70 for a man. To give some idea of how breakfasts can include a third of the day's protein, or about 20 to 24 grams, here are amounts of protein in some familiar breakfast foods:

A cup of milk (1/2 pint), 8 grams; an egg, 6 grams; 2 slices of bacon, 5 inches long, 4 grams; a slice of ham, 2 by 4 inches, 1/4 inch thick, 8 grams; a slice of bread, 2 grams; 3/4 cup cooked or dry cereal with 1/2 cup milk, 6 to 8 grams; 3 pancakes, 4 inches in diameter, 5 grams.

Nutritious Main Dishes

give substance to meals

MAIN dishes that save and satisfy might well be the slogan of every hospital dietitian as she plans meals 365 days out of every year. Main dishes that are attractive, well served, appealing and good to eat are the foundation upon which satisfaction is built. It is a challenge to the person responsible for planning and preparing meals to keep food costs down and still provide food that the patient enjoys eating or that encourages him to eat whether he wants to or not.

Meals are usually planned around a main dish which contains some of the most essential food constituents. For that reason, it is considered the most substantial part of the meal. Generally, the main dish contains the high quality protein foods, such as milk, cheese, eggs, fish, meat and poultry. The legumes, such as dried beans and peas, and peanuts and cereals, also are good protein foods, but they are of better quality when combined with the high quality protein, such as milk and milk products and eggs.

These protein foods give substance to the meal. They give that "stick to the ribs" feeling of being well fed.

MORE EFFICIENT COMBINED

Research has shown that the protein foods with all of their accompanying amino acids, of which there are eight essential ones, are more efficient when combined than when taken separately. Experiments further indicate that the essential amino acids must be obtained ready-made from the daily food, for they cannot be synthesized by the body, nor can the body store them for future use. Also, for effective and efficient use of proteins for tissue growth and regeneration, all of the essential amino acids must be present in the circulation simultaneously and in proper proportions. An interval of only one or two hours between taking these essential amino acids may mean they are wasted for tissue synthesis. Thus, combinations of protein foods become especially important for the person who

MARIETTA EICHELBERGER

Director
Home Economics and
Nutrition Service
Evaporated Milk Association
Chicago

is sick if he is to utilize his food protein for tissue regeneration and thereby shorten his period of convalescence.

A main dish of a combination of high quality protein meets the needs for the essential amino acids in balanced amounts and in the proper proportion. At the same time, it is a good food and good to eat.

Such combinations would seem to indicate the need for using maximum amounts of the costlier proteins. This is not the case. The less efficient, more economical protein mixtures may be supplemented by the more efficient, less economical ones. All protein foods are not equally efficient—notably the vegetable proteins. But when the vegetable proteins are combined with proteins from animal sources, such as milk, cheese, eggs and meat, the amino acids of one type make up for the shortcomings of the other. A combination of these foods into a main dish means the foods are taken together so they are more nutritious as well as more interesting to eat.

In addition to the proteins, with their accompanying amino acids, main dishes can supply an abundance of other food constituents: vitamins A and D; the B vitamins, such as thiamine, riboflavin and niacin, in particular, and certain of the essential minerals, such as calcium and phosphorus and iron. Interestingly enough, a diet that is high in protein will promote the best use of the calcium that is present. Thus, a diet containing a liberal amount of protein aids calcium utilization. With a diet high in calcium, and it can only be high with an adequate intake of milk, the body can make better use of the iron taken from such foods as egg yolk, liver, beef, legumes, vegetables, fruits and the like. These interrelationships point to the need for a combination of

foods such as is possible in main dishes that contain milk, eggs, cheese, fish, meat and the legumes.

Main dishes that contain milk are notable for such nutritive constituents. In addition to providing extra proteins, these are an excellent source of calcium and phosphorus in the right proportions to make the best use of vitamin D. That is true especially of milks which have vitamin D added, usually 400 U.S.P. units per quart or reconstituted quart, as in the case of evaporated milk. These dishes are also an excellent source of riboflavin and the pellagra-preventing niacin because of the content of tryptophane in milk.

ONLY WATER IS REMOVED

All whole milks are equally nutritious. The concentrated milks have had only water removed. Thus, they can be used to give more nutritive value in a smaller volume. Evaporated milk, which has about half the natural water removed by evaporation, can be used as it pours from the can in many main dishes. Such a concentrated product makes it possible also to use the liquid left from cooking vegetables in sauces without giving too "soupy" a sauce. A bit of butter may be added for extra flavor, but for those who need to watch calories, the milk gives all of the "creaminess" needed.

Cheese can be melted in heated and undiluted evaporated milk to make a smooth cheese sauce to be used with cereals, vegetables and in baked dishes. Such smooth cheese sauces are easy to make and they are economical of time and dollars. There are fewer dishes to wash and less time is needed in the making. A casserole dish with such a cheese sauce comes to the patient bubbling hot and tempting to the appetite. A cheese sauce over a green vegetable with a few crisp buttered bread crumbs is truly a one-dish meal, calling only for a dessert, a beverage and perhaps some of your favorite corn meal muffins.

As a binding agent, evaporated milk is invaluable for use in the diets of



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HEINZ 57 PICKLES AND RELISHES

patients who have an allergy to eggs. Then, during those times when eggs are less plentiful and therefore less economical, evaporated milk meets a real need for use in fish loaves, or fish balls, in bean loaves, and the like.

Creamed dishes, like creamed soups, have an enviable smoothness when made with evaporated milk. That eternal problem of leftovers can be handled easily with casserole dishes, loaves and patties. Leftover vegetables, fish, meats, eggs and poultry can be used to advantage to make a dish that is enjoyed more than the original.

While occasionally main dishes are served cold, for the most part they are served piping hot. Casserole dishes served in the modern individual baking dishes can be most attractive. Then, too, they offer a way of bringing to the

patient hot food, because they hold their heat. Also, the casserole makes for neater, more attractive meals. Thick sauces may give foods too gummy an appearance. The ones that are thinner and are held in bounds by the sides of the casseroles are far more interesting and better tasting.

Some main dishes that save and satisfy are suggested in the following recipes. The accompaniments will depend upon your imagination—and remember that variety is the spice of life. Contrasting colors add attractiveness to the meal. Colors in the main dish add eye appeal. Variety of texture is highly important. Serve crisp and crunchy foods with the soft ones. This is why celery hearts are so good with scalloped oysters.

Flavor combinations may determine

whether the meal is acceptable or not. Highly flavored dishes will need to be combined with bland ones. Right temperature of the foods is important. First of all, make foods that are suited to the weather. Some foods are good in winter; others are better in summer. Then, no one needs to be reminded that hot foods should be served piping hot, and cold ones cold. There is nothing more uninteresting than a hot chicken pie topped with cold biscuit.

After your main dishes meet the critical test of being good to eat and good to look at, be sure they are served in the most attractive manner. Serve those foods to your patients with a bit of discrimination, a bit of imagination, and with a lightness that entices the poorest appetite into one that is wide awake.

BEAN LOAF (50 servings)

2 1/4 qt. dried navy beans (4 lb.)	3 cups chopped onion
5 qt. water	1 cup melted bacon fat
2 tbsp. salt	12 eggs
1 1/2 qt. bread crumbs	1 1/2 qt. evaporated milk

Wash beans. Add water and salt and boil for 2 minutes. Remove from heat and let beans soak for 1 hour. After beans have soaked, do not change water. Cover kettle and bring beans to a boil. Continue boiling slowly until beans are tender, about 1 hour. Drain off liquid and save for soup or gravy. Mash beans. Add other ingredients and stir to blend well. Turn into well greased loaf pans and bake in a moderate oven (375° F.) about 1 hour. Serve with tomato sauce.

TOMATO SAUCE (1 quart)

2 tbsp. butter	1/2 cup evaporated milk
2 tbsp. flour	3/4 cup water
3/4 tsp. salt	2 1/2 cups tomato puree
Pepper	

Melt butter. Blend in flour, salt and pepper. Add water and cook until mixture begins to thicken. Add milk and cook until thickened. When ready to serve, add hot tomato puree.

CURRIED RICE AND KIDNEY BEANS WITH CHEESE SAUCE (43 one-half cup servings)

1 cup finely minced onion	2 1/4 qt. cooked red kidney beans
1/2 cup butter	(4 No. 2 cans), drained
3 tbsp. curry powder	3 qt. cooked salted rice (2 lb. raw)

Cook onion slowly in butter about 5 minutes. Add curry powder, beans and rice and heat to serving temperature. Serve with cheese sauce.

BEAN SOUFFLÉ (50 servings)

1 qt. dried navy beans	1 1/2 cups flour
2 qt. water	1/2 cup grated onion
2 tbsp. salt	2 qt. evaporated milk
1 1/2 cups fat	2 doz. eggs, separated

Wash beans. Add water and salt. Boil for 2 minutes. Remove from heat and let beans soak for 1 hour. After beans have soaked, do not change water. Cover the kettle and bring beans to a boil. Continue boiling slowly until beans are tender, about 1 hour. Drain off liquid and save liquid for soup or gravy. Mash beans. Melt fat. Blend in flour and onion. Add milk and continue cooking over boiling water until thick, stirring constantly. Add beaten egg yolks and continue cooking 2 minutes, stirring constantly. Add bean pulp (there should be about 2 quarts). Cool slightly and fold in the stiffly beaten egg whites. Pour into greased shallow baking pan (11 x 15 x 2 inches). Bake in a slow oven (300° F.) until puffy and brown, about 1 hour.

CHEESE SAUCE (43 two and one-third tablespoon servings)

2 lb. American cheese
1 qt. evaporated milk

Cut cheese into small pieces or shred and melt in the milk over boiling water.

MACARONI AND CHEESE (50 servings)

5 lb. macaroni	4 lb. processed cheese
2 gal. boiling water	1 qt. stuffed olives, sliced
3 tbsp. salt	1 qt. bread crumbs, buttered
8 tall cans evaporated milk	

Drop macaroni into rapidly boiling water to which salt has been added. Cook until tender. Drain and rinse. Scald milk over boiling water. Add cheese. Continue cooking until cheese is just melted. Stir to blend well. Add olives. Alternate layers of macaroni and cheese sauce in well greased baking pan. Top with buttered bread crumbs. Bake in moderate oven (350° F.) about 30 minutes.

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**Adding three parts of water to a 6-oz. can of Frozen Concentrated Orange Juice makes a pint and a half of single strength orange juice.

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RICE AND CHEESE LOAF (50 servings)

3 lb. American cheese, grated	1 medium onion, grated
2½ qt. evaporated milk	1 doz. eggs
1½ tbsp. salt	9 qt. cooked salted rice (about,
1½ cups finely cut parsley	3 qt. raw)

Melt cheese in the milk over boiling water. Cook slightly. Add salt, parsley and onion. Beat eggs and combine with cheese sauce. Mix with rice and pour into greased loaf pans. Bake in moderate oven (350° F.) for 1 hour.

Note: For flavor, add 3 cloves garlic to water in which rice is cooked.

CHICKEN RICE CUSTARD (36 servings)

3 qt. cooked salted rice (about	Dash salt
1 qt. raw)	Dash cayenne
1½ qt. diced cooked chicken	6 eggs
2 cups finely cut pimento	1 qt. evaporated milk
	1 pt. chicken broth

Place layers of rice, chicken and pimento in greased baking pan. Sprinkle each layer with salt and cayenne. Top may be decorated with strips of pimento or thin rounds of green pepper. Beat eggs. Add milk and broth. Pour over rice and chicken. Cover and bake in a moderate oven (350° F.) until set, about 30 minutes.

CHEESE FONDUE (50 servings)

2½ qt. soft bread crumbs	5¾ cups evaporated milk
2 tsp. salt	5¾ cups boiling water
1 tsp. dry mustard (optional)	½ cup melted butter
1 tsp. paprika (optional)	2½ lb. finely cut American cheese
	2 doz. eggs

Combine bread crumbs, salt, mustard, paprika, milk, water and butter with cheese. Cool slightly, then add well beaten egg yolks. Beat egg whites until stiff, but not dry, and fold into first mixture. Pour into greased baking pan and bake in a moderate oven (350° F.) until set, about 1 hour.

SAVORY COTTAGE CHEESE SALAD (50 servings)

6 tbsp. unflavored gelatin	3 qt. cottage cheese
3 cups cold water	1½ qt. evaporated milk
6 tbsp. sugar	¾ cup chopped pimento
¾ cup lemon juice	¾ cup chopped green pepper
2 tbsp. salt	¼ cup chopped parsley
6 tbsp. vinegar	3 cups diced celery
	¼ cup minced onion

Soften gelatin in cold water. Dissolve over a bowl of hot water, or in double boiler. Add sugar, lemon juice, salt and vinegar. Blend cheese with milk and add to gelatin mixture. Chill until it begins to set. Fold in vegetables. Rinse pan with cold water and fill with cheese mixture. Chill until set.

FISH SOUFFLÉ (35 servings)

1 cup butter	3 cups dry bread crumbs
3 cups flour	½ cup minced parsley
1½ tbsp. salt	¼ cup onion juice
1 qt. boiling water	3 qt. flaked cooked fish
1 qt. evaporated milk	2 doz. eggs

Melt butter. Add flour and salt. Stir to blend well. Add water and cook until sauce begins to thicken, stirring constantly. Add milk. Set over boiling water and continue cooking until thick. Add bread crumbs, parsley, onion juice and fish. Add beaten egg yolks. Fold in stiffly beaten egg whites. Pour into greased baking pan. Set in pan of hot water. Bake in a slow oven (325° F.) until set, about 1½ hours.

SALMON LOAF WITH GRITS (2 loaves, 14 to 16 servings)

1 cup grits	2 tall cans evaporated milk (3½ cups)
1 pt. boiling water	1 lb. canned salmon
1 tsp. salt	4 eggs

Sift grits into boiling water to which salt has been added. Boil until thick about 5 minutes, stirring occasionally. Add milk and set over boiling water. Cover and cook 25 minutes longer, stirring occasionally. Remove from heat. Add salmon. Cool slightly, beat in the eggs and turn into a well greased loaf pan. Bake in a moderate oven (350° F.) until set, about 30 minutes.

CURRIED SHRIMP WITH RICE (50 two-third cup servings)

1 cup butter	2 qt. boiling water
1 cup finely chopped onion	2 qt. evaporated milk
1 cup flour	4 qt. canned or freshly cooked shrimp
½ cup curry powder	4½ qt. cooked salted rice (3 lb. raw)
2½ tbsp. salt	1 qt. cooked peas
1/16 tsp. cayenne	8 pimientos, diced

Melt butter. Add onion and cook slowly without browning for 5 minutes. Blend flour, curry powder, salt and cayenne, and stir into butter and onion. Add the boiling water slowly, stirring until smooth. Add milk and shrimp and cook over boiling water until sauce is thickened. Toss rice, pea and pimiento lightly together. Press into custard cup or scoop to shape. Turn onto hot serving plates and pour curried shrimp around rice molds. Serve with chutney or freshly grated coconut, or both.

ESCALLOPED OYSTERS

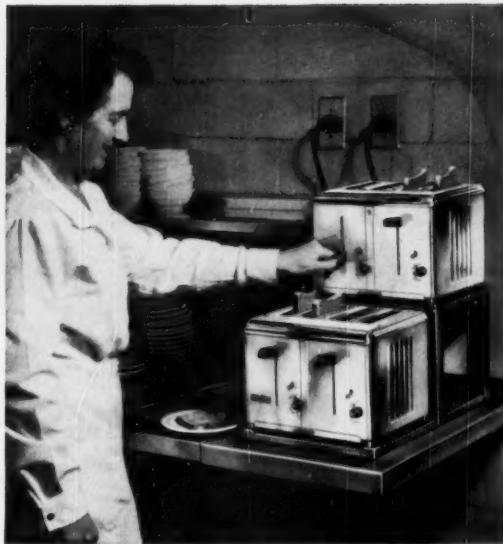
(48 servings, 2¾ by 2½ by 1¼ inches)

2 cups melted butter	½ tsp. cayenne
3 qt. coarse cracker crumbs	1 tsp. marjoram (optional)
4 qt. oysters and liquor	2 pt. thyme (optional)
3 tsp. salt	2 qt. evaporated milk
½ tsp. pepper	Paprika

Mix butter with cracker crumbs. Spread about one-third of crumbs in greased shallow baking pan. Cover with half the oysters. Season with salt, pepper, cayenne and marjoram and thyme, if desired. Repeat with another layer of crumbs and oysters. Top with remaining crumbs. Add milk. Sprinkle paprika on top. Bake in moderately hot oven (400° F.) for 40 minutes.



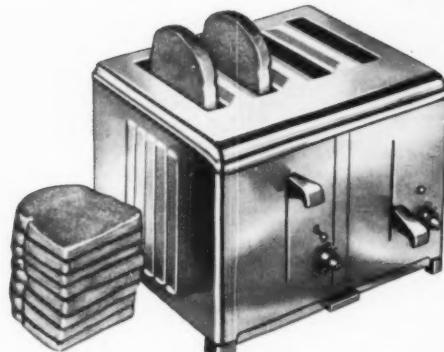
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Menus for August 1950

Clarisse Anderson Dean
University Hospitals
Columbia, Mo.

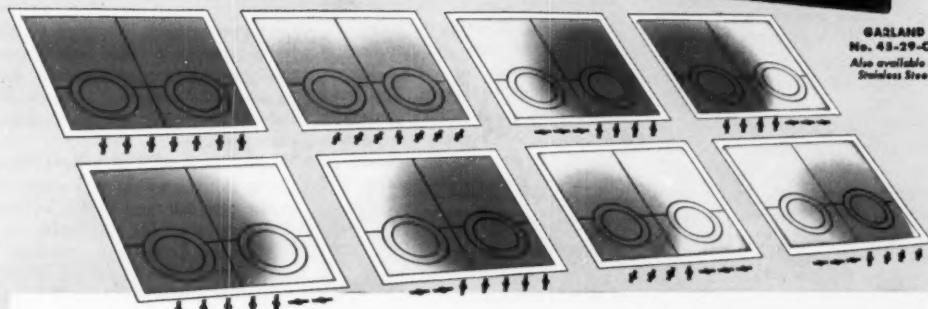
1	Grapefruit Juice Scrambled Eggs, Toast	2	Orange Juice Bacon, Toast	3	Cantaloupe Soft Boiled Egg, Toast	4	Grapefruit Segments Eggs to Order, Toast	5	Stewed Prunes Bacon, Toast	6	Orange Half Assorted Sweet Rolls
	Broiled Ham with Sliced Pineapple Mashed Sweet Potatoes Coleslaw-Tomato Wedges Delicia Cake		Broiled Steak Stuffed Potato Stuffed Vegetable Salad Cherry Upside-Down Cake		Roast Pork Loin Glazed Carrots Buttered Broccoli Wilted Lettuce Fresh Apple Pie		Salmon Salad French Fried Potatoes Buttered Asparagus Vienna Rolls, Jam Orange Ice Sponge Cake		Fried Chicken with Cream Gravy Parsley Buttered Potato Buttered Green Peas Pimento Coleslaw Fresh Sliced Peaches on Angel Food		
	Swedish Meat Balls, Mushroom Sauce Corn-on-the-Cob Apricots		Tongue and Cheese Sandwiches Buttered Wax Beans Celery and Pickle Sticks Sliced Fresh Peaches Icebox Cookies		Creamed Chipped Beef Mashed Potatoes Sliced Tomato Salad Hot Biscuits Chocolate Blanmange, Whipped Cream		Omelet, Spanish Sauce Buttered Green Beans Banana Nut Salad Icebox Dessert		Hamburger on Bun Potato Chips Tossed Green Salad Watermelon		
7	Tomato Juice Poached Egg on Toast	8	Blended Fruit Juice Eggs to Order, Toast	9	Grapefruit Segments Omelet, Toast	10	Pineapple Juice Sausage Links, Toast	11	Tomato Juice Eggs to Order, Toast	12	Cantaloupe Bacon, Toast
	Baked Pork Chops Baked Sweet Potatoes Creamed Cauliflower Apple Crisp		Braised Liver, Mushroom Sauce Ricotta Potatoes Buttered Summer Squash Wilted Lettuce Honey Dew Melon		Baked Canadian Bacon Corn-on-the-Cob Broiled Tomatoes Yankee Coleslaw Hot Rolls Applesauce		Chicken Salad Waffle Potatoes Creamed Wax Beans Parker House Rolls Melon Cup		Fried White Fish, Tartare Sauce Escalloped Potatoes Buttered New Beets Dill Coleslaw Lemon Pie		
	Roast Beef Sandwich Buttered Rice Sliced Tomato Salad Fruit Punch Date Bars		Bacon Curls Carrot Cutlets Current Jello Stuffed Celery Plain Muffins Stewed Fresh Peaches		Meat Loaf, Spanish Sauce Potato Puffs Buttered Spinach Fresh Fruit Salad Icebox Cookies		Cube Steak Creole Noodles Chef's Salad Burnt Sugar Cake		Shrimp and Egg Salad Rice with Tomatoes Buttered Green Peas Orange Ice Sugar Cookies		
13	Sliced Bananas Assorted Sweet Rolls	14	Apricot Nectar Soft Cooked Egg, Toast	15	Grapefruit Segments Muffins, Jam	16	Sliced Orange Scrambled Eggs, Toast	17	Stewed Prunes Sausage Cakes, Toast	18	Stewed Prunes Bran Muffins, Jam
	Roast Pork Loin Buttered New Corn Pimiento Cauliflower Vienna Rolls Apple-Orange-Grape Salad Chocolate Sundae		Braised Short Ribs of Beef Franconia Potatoes Minted Carrots Lettuce with Caper Dressing Orange Floating Island		Chicken à la King Anna Potatoes Buttered Asparagus Tossed Salad Watermelon		Baked Ham Buttered Green Lima Beans Broiled Tomatoes Pineapple Salad Ice Cream		Baked Hamlet with Lemon Slices Creamed Potatoes and New Peas Fresh Pear Salad Butterscotch Pudding		
	Cold Cuts Potato Salad Celery and Ripe Olives Sponge Cake		Bacon and Tomato Sandwich Potato Chips Iced Cocoa Icebox Cookies		Baked Smoked Tongue, Raisin Sauce Baked Acorn Squash Harvard Beets Fresh Peach Cobbler		Hamburger Balls, Mushroom Sauce Corn-on-the-Cob Mixed Green Salad Icebox Dessert		Salmon Cakes, Cheese Soufflé, Buttered Rice Asparagus Salad Limeade Ginger Cookies		
19	Cantaloupe Poached Egg on Toast	20	Applesauce Coffee Cake, Bacon	21	Grapefruit Segments Creamed Beef on Toast	22	Fresh Pears Scrambled Eggs, Toast	23	Honey Dew Melon French Toast	24	Orange Juice Soft Cooked Egg, Toast
	Roast Beef with Brown Gravy Mashed Potatoes Stewed Fresh Tomatoes Lettuce with 1000 Island Dressing Honey Dew Melon		Veal Cutlets with Pan Gravy Potato Cubes with Chive Butter Buttered Green Beans Apricot Salad Whole Wheat Rolls Ice Cream Bars		Roast Spare Ribs, Spanish Sauce Oven-Browned Potatoes Buttered Broccoli Wilted Lettuce Vanilla Pudding		Stewed Chicken with Dumplings Chef's Salad Boston Cream Pie		Baked Pork Chops with Dressing Buttered Green Lima Beans Red and White Cabbage Slaw Apple Tapioca with Whipped Cream		
	Frankfurters in Coney Islands Potato Salad Celery Hearts Fruit Bowl		Tuna Salad Finger Sandwiches Potato Chips Carrot and Turnip Sticks Royal Anne Cherries Angel Food		Baked Stuffed Peppers Mashed Potato Potatoes Bretz and Egg Salad Bavarian Cream		Breaded Liver Hashed Browned Potatoes Creamed New Onions Sliced Tomato Salad Melon Cup		Salisbury Steak Creamed Fresh Corn Broiled Tomatoes Bran Muffins, Jam Pineapple Cubes		
25	Grapefruit Juice Eggs to Order, Toast	26	Orange Half Bacon, Toast	27	Pineapple Juice Coffee Cake	28	Tomato Juice Scrambled Eggs, Toast	29	Kadota Figs Eggs to Order, Toast	30	Honey Dew Melon Bacon, Toast
	Tuna and Noodle Casserole Glazed Carrots Spinach Salad Vienna Rolls Raspberry Ice		Pork Patties Buttered Green Beans Creamed New Peas Cinnamon Apple Rings Chocolate Pudding		Fruit Cup Fried Chicken with Cream Gravy Parsley Buttered Potato Relishes Date Torte with Whipped Cream		Ham Loaf Stuffed Baked Potato Stewed Tomato with Okra Carrot Salad Floating Island with Orange Slices		Swiss Steak Whipped Potatoes Tomato and Lettuce Salad Melon Cup Cup Cakes		
	Omelet with Sardines Pittsburgh Potatoes Tomato Salad Baked Fresh Pears Cup Cakes		Chopped Hash Buttered New Beets Chef's Salad Hot Biscuits Fresh Fruit Bowl		Chicken Salad Sandwich Potato Chips Buttered New Peas Sliced Tomatoes Honey Dew Melon		Broiled Lamb Chops Succotash Waldorf Salad Chocolate Sundae		Spaghetti with Meat Balls Buttered Peas Coleslaw Sliced Fresh Peaches Coconut Macaroons		
31	Grapefruit Segments, Link Sausages, Muffins Sundae • Cold Cuts, Potato Salad, Spiced Pears, Sliced Peaches on Plain Cake with Whipped Cream										

Ready-to-eat or cooked cereals are offered on all breakfast menus.

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Give Unequaled Top
Heat Flexibility! ONLY

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*REG. U. S. PAT. OFF.

Maintenance and Operation

Fire Extinguishers

their selection, maintenance and use

Part II

LAST month I discussed four of eight recognized types of fire extinguishers. In this article I shall discuss the other four types. The third and concluding installment in this series will appear in the August issue.

CARBON-DIOXIDE TYPE

Carbon dioxide (CO_2) is the name of a compound that exists as a gas at ordinary atmospheric temperatures and pressures. In addition to being approximately one and one-half times heavier than air, carbon dioxide is chemically rather inert and will not support combustion. It can be stored in containers, as either a liquid or a gas, and quickly discharged therefrom, through suitable nozzles, by means of its own storage pressure as the expelling force.

The fire extinguishing action of carbon dioxide is due principally to its smothering action, i.e. exclusion and dilution of oxygen. In the process of discharging the gas from its container, a portion may freeze to carbon-dioxide snow at a temperature of -110°F . Some cooling effect may result, but this is minor, compared to its smothering effect, when carbon dioxide is used in small quantities.

Carbon-dioxide extinguishers make use of these properties of the gas. The hand portable sizes consist basically of a metal storage cylinder, a valve release mechanism, and a means of effectively applying carbon dioxide on the fire. Since the gas pressure within the fully charged cylinder is relatively high (approximately 850 pounds per square inch at 70° F .), these vessels are designed for a service pressure of 1800 pounds per square inch or more under Interstate Commerce Commission regulations and are so marked. All cylinders must withstand a hydrostatic test pressure of $5/3$ the service pressure when new and must be retested at least every five years.

Safety disks are provided in the valve head that are designed to rupture

WILLIS G. LABES

Assistant Professor
Fire Protection Engineering
Illinois Institute of Technology

at pressures lower than the test pressures for protection in case the cylinders are involved in a fire. A tube extends from the valve to the bottom of the cylinder so that only liquid carbon dioxide reaches the discharge horn until about 80 per cent of the contents has been discharged (at normal temperature), after which gaseous carbon dioxide is discharged.

To operate this type of extinguisher, hold in an *spright* position, pull the safety pin and open the discharge valve while properly directing the horn.

The size of these extinguishers is stated in pounds of carbon-dioxide charge within the bottle. The hand portable sizes are available in capacities of 2 pounds, $2\frac{1}{2}$ pounds, $3\frac{3}{8}$ pounds, 4 pounds, 5 pounds, $7\frac{1}{2}$ pounds, 10 pounds, 15 pounds, 20 pounds, and 25 pounds.

SUITABLE FOR LIQUID FIRES

These extinguishers are classified as suitable for flammable liquid fires (class B). Since the "snow" and gas are nonconductors of electricity, if the discharge horn is nonmetallic these extinguishers are approved for use on fires involving electrical equipment (class C). They are not effective on deep seated class A fires but may be of value for surface fires in small quantities of such materials where the smothering effect of the gas may be utilized. Complete extinguishment in such cases will likely require the use of water. These extinguishers are assigned a classification or rating, depending upon size.

Maintenance consists chiefly of keeping the extinguisher fully charged at all times and of ensuring that it has not been tampered with or subjected to mechanical injury. This can be accomplished by periodic inspection,

by recharging it promptly after use (even though the entire contents may not have been discharged), and by a detailed examination at least once a year, preferably semiannually.

Since recharging involves handling gas under high pressure, special equipment is necessary to do this work. Most often, these extinguishers are sent away to be recharged, either by the manufacturer or by a concern equipped and with experience to handle this work properly. However, when a sufficient number of carbon-dioxide extinguishers are involved at any one location, it may be economically practical to purchase recharging equipment. If this plan is followed, only carefully trained personnel should be assigned to this work. Cylinders are required to be hydrostatically tested at least every five years. If the extinguishers must be sent out for recharging, additional fully charged extinguishers should replace them.

The quantity of carbon-dioxide charge existing within the extinguisher at any time can most readily be determined by weighing, preferably on a scale of the beam type graduated to read directly in ounces. If the *net weight* of the carbon dioxide is less than 90 per cent of that marked on the extinguisher, it should be recharged.

Carbon-dioxide extinguishers also are available in wheeled units of 50, 75 and 100 pounds' capacity, equipped with a valved discharge horn connected to 15, 25 and 40 feet of hose, respectively. Units of this size that are equipped with metal discharge horns are not approved for use on electrical fires because of the shock hazard. Maintenance of these large sizes is similar to that of the small, hand portable types.

FOAM TYPE

The fire extinguishing agent expelled by this type of unit is a foam consisting of carbon-dioxide gas enclosed in a tough film, forming a closely knit blanket of bubbles that

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Fleximatic FOLDER

GREATER FLEXIBILITY — Automatically measures and folds linens ranging in size from 20" to 120" wide and 24" to 108" long. Linens are folded twice lengthwise with edges buried. Usable with any flatwork ironer.

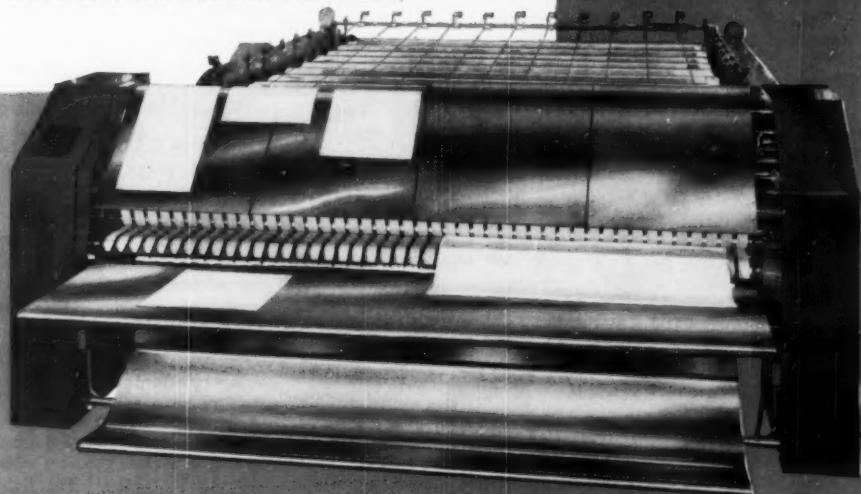
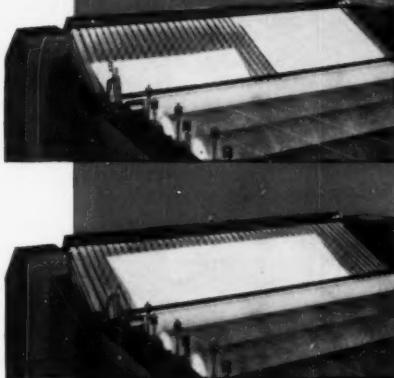
SAVES TIME AND LABOR — Eliminates the labor of two girl "catchers" normally used in hand folding. Folds as fast as the girls can feed and the ironer can dry.

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will float on the surface of most burning flammable liquids. The effect is to smother the fire by excluding oxygen. The blanket of foam persists for some time and prevents re-ignition of the fire from outside sources. Of first importance to remember is that the blanket of foam must be complete to effect extinguishment. If a small patch of liquid surface is left uncovered and burning, the foam blanket will be progressively destroyed by the heat of the flame—until all of the liquid surface is again afire. Foam may be rather stiff and again it may be watery, depending upon the mix. A foam that will flow and spread fairly quickly over the burning liquid surface is desirable.

The foam is the product of a chemical reaction between sodium bicarbonate and aluminum sulfate. It consists of an inner container filled to the proper level with a water solution of aluminum sulfate, an outer shell filled to the proper level with a water solution of sodium bicarbonate, and a discharge hose and nozzle. The sodium bicarbonate solution also contains a foam stabilizing agent to toughen the film forming the bubbles.

HOW IT WORKS

A cap with a rubber gasket screws on to a threaded collar at the top of the shell. A lead stopple fits loosely in the top of the inner container. When the extinguisher is inverted, the stopple will drop, permitting the two solutions to mix and generate foam. The gas pressure within the extinguisher serves to expel the foam. The extinguisher must remain inverted during operation.

Foam extinguishers, of the hand portable size, are available in 1½, 2½ and 5 gallons' capacity. The commonest size, 2½ gallons' capacity, will generate from 18 to 20 gallons of foam and will discharge it through a horizontal range of 30 to 40 feet over a period of 60 seconds, if properly charged. Materials for charging should be purchased directly from the manufacturer of the extinguisher.

Underwriters' Laboratories, Inc. has assigned an A-1 classification, as well as B-1 classification, for the 2½ gallon size, since it must be capable of extinguishing a standardized class A fire. The foam stream is a conductor of electricity; therefore, this type is *not* approved for use on class C fires.

These extinguishers are relatively ineffective on fires involving such liquids as alcohols, acetone and lacquer thin-



Fig. 1. Wheeled Foam Type.
Maximum effective range of this
type varies from 38 to 50 feet.

ners, such as butyl and amyl acetates, which break down the foam. Carbon disulfide and ethyl ether have low boiling points; when foam is applied to a fire in these liquids, the vapors may continue to penetrate the foam blanket and burn above it. Carbon disulfide and ether also break down foam considerably.

Maintenance of foam extinguishers is similar to requirements for soda and acid extinguishers. Periodic inspections and annual discharge and recharge are required. Under certain conditions the solutions in foam extinguishers deteriorate rapidly and it is important that they be freshly charged once each year. When located where continued temperatures lower than 40° F. may be encountered, extinguishers of this type must be placed in suitable heated cabinets. Freezing of the solutions will seriously weaken or burst the shell.

After the extinguishers have been operated, the inner container and stopple should be removed and carefully cleaned; the interior of the extinguisher should be thoroughly washed out. The discharge outlet screen should be carefully examined to make sure all the holes are free. The hose should be blown out or removed and water run through to clear any obstruction. The shell and inner container are filled with the proper solution to the level indicated.

Each chemical should be put into solution by mixing it with water in a separate, clean vessel and then strained into its respective container to prevent undissolved particles from entering and clogging the hose and nozzle

or screens at outlet elbow. Then the inner container is placed in position and the stopple is seated. Before screwing the cap into place, check the rubber gasket; if in poor or doubtful condition, replace it.

The shells of these extinguishers are required to withstand a hydrostatic test of 350 pounds per square inch pressure for one minute without leakage or permanent distortion. This requirement is to prevent failure of the shell by internal pressure generated during operation. Therefore, both periodic inspection and thorough examination at time of recharging should include careful attention to weakness caused by mechanical injury, by freezing or corrosion. A doubtful extinguisher should not be returned to service.

Foam extinguishers also are available in wheeled units of 10, 17 and 33 gallons' capacity. Figure 1 is typical of these sizes. The 10 gallon unit discharges through 9 feet of ¾ inch hose; the 17 and 33 gallon units discharge through 25 and 50 feet, respectively, of 1¼ inch hose; all units have ⅜ inch shut-off nozzles. Maximum effective range varies from 38 to 50 feet. Time of operation may be from 2½ to 3½ minutes. Some designs differ in operation from the small units in that a manually operated stopple must be opened to allow the solutions to mix when the container is tipped. Maintenance of these large units is similar to that of the smaller extinguishers.

VAPORIZING LIQUID TYPE

The extinguishing medium used in this type of unit is a special, highly volatile, electrically nonconductive liquid having carbon tetrachloride as its base. The carbon tetrachloride used is commercially known as "fire extinguisher grade," from which corrosion producing impurities have been removed and to which have been added important components for depressing the freezing point to 50° F. below zero.

The extinguishing effect of this liquid is due primarily to the smothering action of the heavy blanket of vapor developed by the heat of the fire. One quart of liquid produces about 10 cubic feet of vapor. The liquid has little cooling effect because of its relatively low capacity for heat absorption upon vaporization.

Extinguishers of the vaporizing liquid type are available in three prin-

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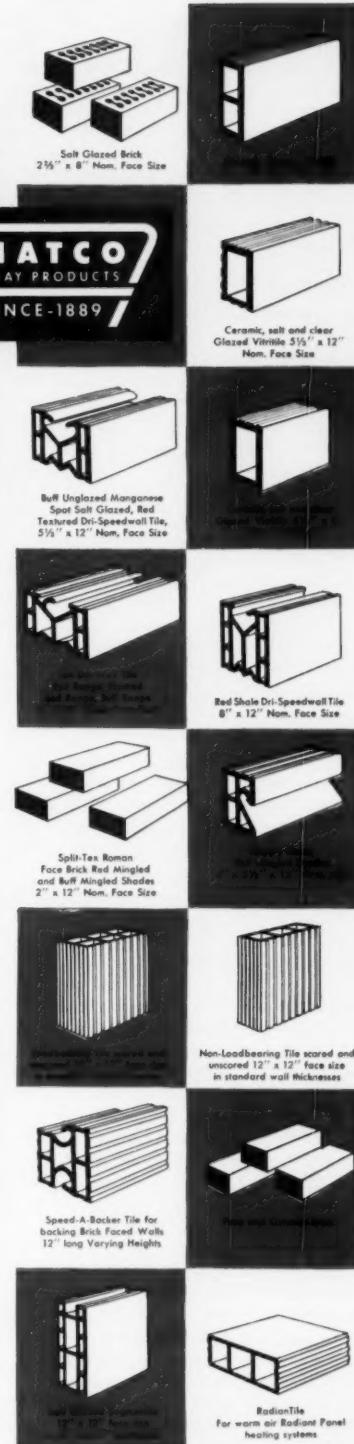
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cipal designs: the pump type, the stored air pressure type, and the stored carbon-dioxide pressure type. The first design mentioned utilizes a hand operated pump to expel the liquid. The pump discharges liquid on both strokes of the piston rod. These extinguishers are available in 1, 1½, 1½ and 2 quart capacities, as well as in 1 and 2 gallon capacities. Effective range is approximately 20 to 30 feet.

BEST FOR ELECTRICAL FIRES

The stored air pressure type has a built-in, hand operated air pump by means of which air, under 100 pounds' per square inch pressure, is compressed in a separate chamber within the unit and maintained until the extinguisher is used. Air pressure is indicated on a gauge attached to the unit. This design is available in 1, 2, 3 and 3½ gallon capacities. A half-gallon size in this general design has valve connection through which air pressure can be built up by means of a tire pump or other air supply; the hand operated air pump built in to the unit is thereby eliminated. Effective range is approximately 20 to 30 feet. (See figure 2.)

The stored carbon-dioxide pressure type is available in two sizes, 1 and 2½ quart capacities, in which the gas is stored in the extinguisher shell above the liquid, the pressure being indicated by a small gauge. A 1 gallon size is available, utilizing a carbon-dioxide cartridge with an arrangement for puncturing a sealing disk to release the gas and discharge the liquid. Approximate range is from 18 to 25 feet.

Vaporizing liquid type extinguishers are best used for electrical fires, although they are of recognized value for use on small flammable liquid fires. Under fire conditions in which voltages of the order of 15,000 volts or fewer are involved, a practical margin of safety is provided against conductivity of the liquid stream by holding the extinguisher nozzle a distance of 12 inches or more from current carrying electrical parts.

In using extinguishers of this type, especially in unventilated spaces, such as small rooms, closets or confined spaces, operators and others should take precautions to avoid the effects that may be caused by breathing the vapors or gases liberated or produced. When carbon tetrachloride comes in contact with the heat of a fire it decomposes, at least partially, into carbon and chlorine; hydrogen chloride gas is usually

formed and traces of phosgene usually can be found. Whatever reactions take place, those in the vicinity of a fire upon which carbon tetrachloride has been discharged will likely be driven away by the irritating effect of the gases present.

One of the most important maintenance items to remember is *never* to use water for any purpose in extinguishers of this type. Water will introduce serious corrosion problems. Use the vaporizing liquid supplied by the extinguisher manufacturer. Use of commercial grade carbon tetrachloride is likely to produce serious corrosion within the extinguisher; also, this grade of liquid has not been treated to depress the freezing point. Obviously, it is important that the extinguishers be kept full of liquid (to the filling mark on stored pressure types) at all times and be refilled immediately after use. Periodic inspection should include examination to make sure that the extinguishers have not been tampered with or removed from their designated places; to detect any injuries; to see that they are full of liquid; to check the gas pressure in the stored pressure types, and to see that the orifice of the nozzle is not clogged.

At least once yearly the extinguishers should be examined as to the condition of the pump or pressure or weight of the cartridge. At these inspections, operation of the extinguisher should be tested by discharging some

of the liquid. In making this test, those types with hand pumps should be pointed both up and down to make sure that the internal pump takes suction from both ends of the tank. Pump parts should be carefully inspected, as far as possible, for any apparent corrosion. A leaking or inoperative extinguisher should be either discarded or returned to the manufacturer for repairs, depending upon its condition.

LOADED STREAM TYPE

The extinguishing agent in this type of unit is a water solution of an alkali-metal salt that has a freezing point of about 40° F. below zero; although the exact composition of the charge is a trade secret, it is known that potassium salts form a portion of the mixture. The effect of the "loaded stream" solution on fire differs from that of other extinguishing agents. On class A fires the stream extinguishes the flame rather suddenly, and there is a pronounced fire retarding effect. The effect on certain small class B fires has not been explained. There is no smothering vapor produced to blanket the fire, but apparently there is a chemical reaction tending to inhibit oxidation.*

The loaded stream type of extinguisher is obtainable either with a carbon-dioxide cartridge for expelling the solution or in a design using a chemical reaction to produce gas expelling pressure. Sizes available are 1, 1½ and 2½ gallons in hand portable types, and 17 and 33 gallons' capacity in wheeled types. The hand portable sizes are, in appearance, much like the soda and acid or the water filled extinguishers of the gas cartridge type. Underwriters' Laboratories, Inc. and the National Board of Fire Underwriters have approved loaded stream extinguishers as effective on class A fires, and only the 1½ and 2½ gallon sizes on small class B fires. The Factory Mutual Laboratories does not recognize this type as suitable for use on class B fires. Since the discharge stream is a conductor of electricity, its use on class C fires is not recommended.

Maintenance of the loaded stream type of extinguisher is similar to that of comparable units of the soda and acid and gas cartridge type of water filled extinguishers. Only recharging materials supplied by the manufacturer should be used.

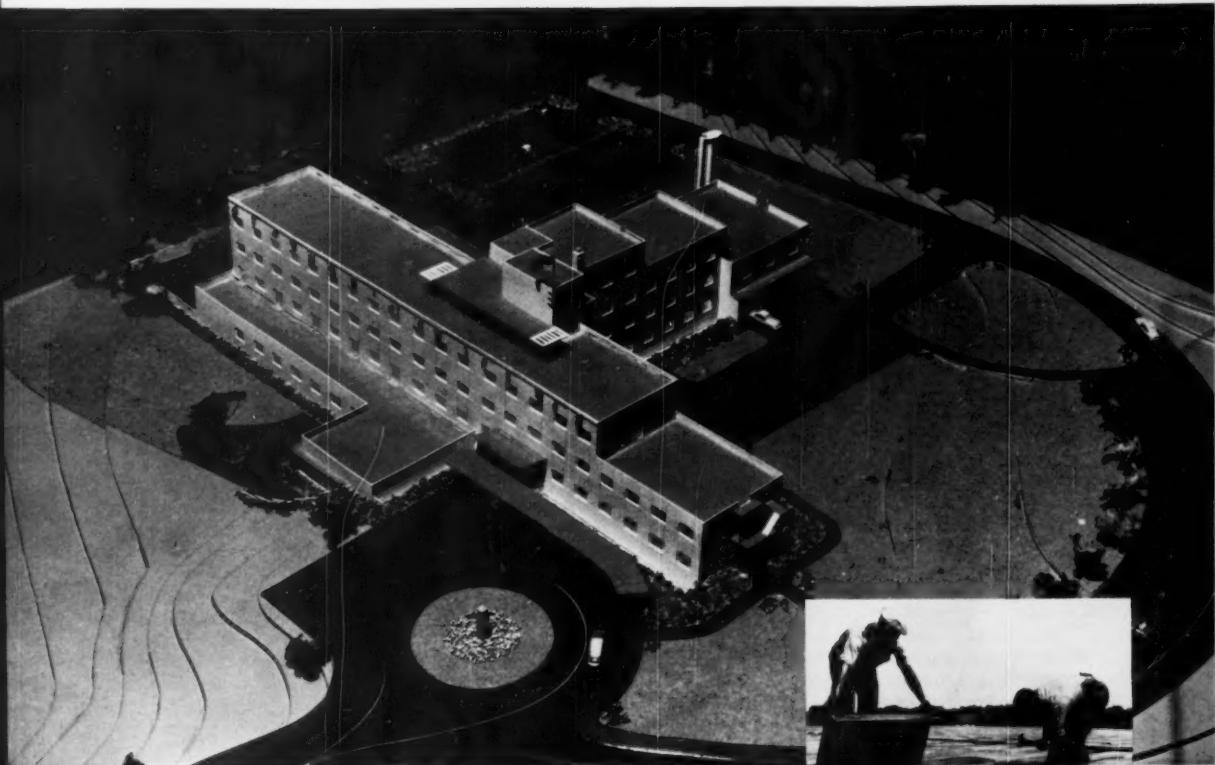
(To Be Concluded.)

*N.F.P.A. Handbook of Fire Protection, 10th Edition.



Fig. 2. Vaporizing Liquid Type. Available in three principal designs, the extinguisher shown above is the stored air pressure type.

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Housekeeping

Conducted by Alta M. La Belle and Jane Barton

How the housekeeping department can help to make the hospital a

ZONE OF QUIET

MAE STARK

Executive Housekeeper
Nurses' Residence
Presbyterian Hospital
Newark, N.J.

HOSPITAL Quiet Zone." This sign, displayed near any hospital, is a familiar landmark. The traveling public will not knowingly make noise to disturb a sick person. But what happens inside the institution is another story. Is it because the sick are ever with us, and we forget what peace and quiet mean to one who is trying to regain strength through rest and sleep?

It would seem at times as if our employees were putting on a campaign to see how much noise they can make—and the patients can take. It is all part of the pressure of work. Each one in his own way is trying to do a job and one cannot always go about it quietly.

The architect is problem Number 1 and not a small one at that. If more architects would consult with housekeepers before building a hospital (this is particularly true where a program of rebuilding or renovation is considered), these mistakes could be avoided and a better idea of what is needed could be obtained.

Housekeeping today is more than a "mop and bucket" program. A place for all the various brushes, mops and brooms should be planned. The cost of construction and lack of space are always factors but afterward the upkeep becomes the administrator's problem as long as the building stands, frequently as a monument to false economy.

Maids' and porters' hoppers should be large enough so that the employee can walk in, close the door and use the slop sink without disturbing patients with banging of pails, drawing water and other necessary activity. Let it be *their* hopper and let us not add to it other items not wanted elsewhere.

The introduction of steel into our public buildings has caused a noise problem. Steel doors and window frames without silencers are extremely

noisy, as are doors of laundry chutes, elevators in corridors, and dumbwaiters.

No one would quarrel with the nursing department if it did everything possible to avoid spreading disease or infection. But look into any utility or work room! You will find the noise of a boiler factory is sweet music at times in comparison with the banging of bedpan flushers, blanket warmers, linen chute doors, and sterilizers—just a few of the necessary functions of this department. On sinks, drainboards and tables of stainless metal, rubber mats could be used to silence the noise of pans and basins on hard metal surfaces.

Durability *versus* cost revives an old headache. Cost exceeds income. Each department is asking for more and better equipment, and the purchasing agent is trying to stretch her budget dollar to buy the items that will give the longest service for the money. Again, we have metal sinks, pails, pans, pitchers, drinking cups, wagons, urinals and bedpans. Check any institutional magazine. About one out of every 25 manufacturers will say its product is "quiet," "silent" or "noiseless."

What has been done so far? Manufacturers of vacuum cleaners, floor buffers, and other motorized equipment are starting to realize the need for quieter operating machines. Some

This month we again interrupt the Boston University housekeeping course. The remaining lectures in the Boston series will appear in forthcoming issues of the magazine.

manufacturers are adding rubber bumpers to service trucks (this means a saving of walls, too). Elevator companies are putting silencers on lifts. Quite recently I had a brush salesman point out a rubber bumper on a push broom. Carpet sweepers have long had a rubber roll around the box holding brushes and pan. Rubber bumpers are appearing on bedpan sterilizers, but so far we have noticed little improvement on housekeeping equipment.

Some things the housekeeper can do in her training program are to suggest rubber heels and stress the need for maids and porters to drop voices as low as possible and to proceed about their jobs without banging doors, mop handles, and other working equipment. The rattling of keys when they are used should be avoided. Congregating in work areas and chattering is a noisy, and usually unnecessary, practice.

In training employees, the need for proceeding quietly about the job can be stressed. Visual aids, emphasizing the need for a quiet atmosphere, are a great help. A funny picture frequently carries the point in a flash. Just a card reading "Silence" left up for months is of little use.

Silencers on hinges or door checks help considerably to lessen door banging. Windows should be constructed so that they can be opened and closed quietly; elevator doors should close silently. Service centers removed to a remote section and not placed opposite patients' rooms would be an improvement.

While a great many of the noises are not of housekeeping origin, we can at least do our part to avoid adding to the din. Maybe eventually our patients will say "I did rest," rather than, as one patient said within my hearing, "The hospital is a good place to get well but one has to go home to rest."

The big need for study should start with architects and engineers. Our maintenance men also need to do some research. Did you read Mildred Whitcomb's article in the July 1949 issue of *The MODERN HOSPITAL*?* We have a great deal of sympathy with Dr. Ivy. Let us do some thinking and planning in the housekeeping department to make the patient's stay a little pleasanter.

*Whitcomb, Mildred: The Ten Days of Dr. Ivy, *Mod. Hosp.* 73:46 (July) 1949.

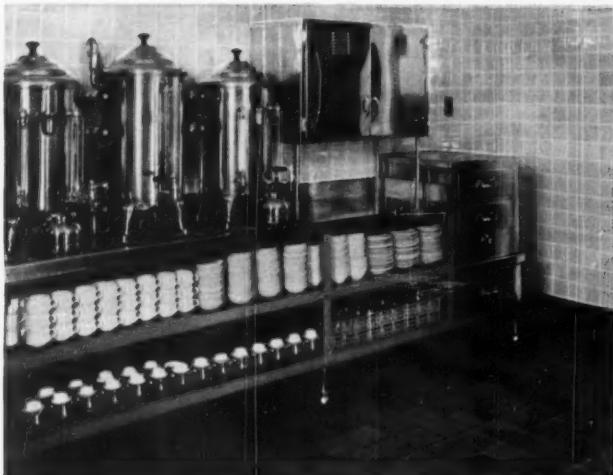


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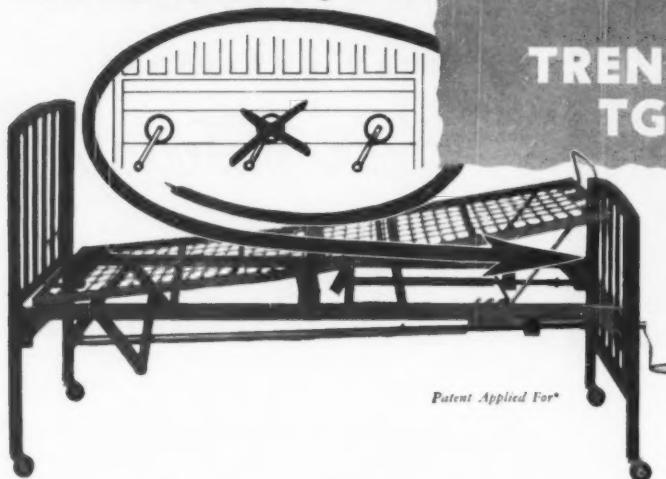
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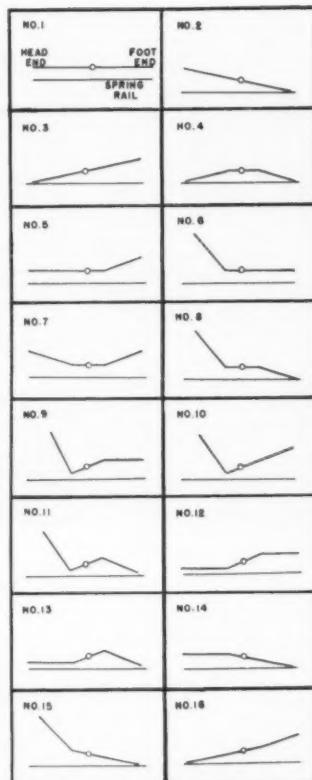
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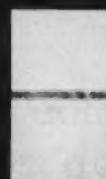
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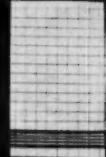
16" striped glass toweling



16" name glass toweling



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Jacquard napkin (pattern)



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NEWS DIGEST

1300 Attend Middle Atlantic Assembly . . . A.M.A. Delegates Study Hess Report . . . Start Cancer Hospital at Chicago . . . Plan to Increase A.H.A. Dues . . . Montefiore Hospital Starts Social Medicine Division . . . Appoint Residents

Middle Atlantic Hospital Assembly Discusses Nursing, Intern, Government Problems

BUFFALO, N.Y.—More than 1300 hospital people from Pennsylvania, New York and New Jersey attended the second annual Middle Atlantic Hospital Assembly here May 24 to 26. The program featured general assembly meetings during the afternoons and separate sessions of the three state hospital associations during the mornings.

At the first general assembly discussion centered on nursing problems and the supply and selection of interns. Dr. Herbert M. Wortman of Montclair, N.J., reported that the cost of nursing education had doubled in 10 years and that the practice of "loading" nursing education costs on private hospital patients would have to be discontinued. He suggested increased tuition fees and government aid as sources of funds which could help hospitals carry increasing educational costs.

At the same meeting, Helen L. Bunge, dean of Western Reserve University's school of nursing, said professional nurses should concentrate more attention on the psychological needs of hospital patients, leaving routine bedside duties to auxiliary or nonprofessional nursing workers. Miss Bunge said the leader of the hospital nursing team should remain responsible, however, for total nursing care of patients and for teaching all classes of nursing personnel.

In discussing the internship problem, F. Stanley Howe of Orange, N.J., pointed out that the number of approved internships had increased 40 per cent over a period during which the annual number of medical graduates had increased only 10 per cent. Dr. Edward H. Leverroos, a member of the staff of the Council on Medical Education and Hospitals of the American Medical Association, warned that the intern shortage was being augmented by con-



Above: Board of governors [l. to r.]: John F. Worman; Robert W. Gloman (new president); J. Harold Johnston. Below: New presidents: A. W. Eckert, New Jersey; Moir P. Tanner, retiring president of the assembly; Alma M. Troxell, Pennsylvania, and Carl P. Wright Jr. of New York State.



struction of many new hospitals and expansion of existing institutions. He suggested that two-year internships would help relieve the problem.

Dr. John J. Bourke, executive director of the New York State Joint Hospital Survey and Planning Commission, reviewed the public health functions of the voluntary hospital.

The second general session was devoted to discussion of government and public relations in the hospital field. Speaking for the American Hospital Association, John N. Hatfield, president, deplored the insistence of veterans' organizations and politicians on expansion of the Veterans Administration

(Continued on Page 160.)

Start Construction on Cancer Research Hospital at University of Chicago

CHICAGO.—Construction was undertaken here last month on a \$3,500,000 cancer research hospital to be built on the University of Chicago campus by the Atomic Energy Commission. The hospital will be known as the Argonne Cancer Research Hospital and will include 50 beds and facilities for detailed clinical investigation in the treatment of various types of cancer with radioactive materials. Schmidt, Garden & Erikson of Chicago are the architects for the project.

Special features of the new clinical research center, which will be operated by the university under an agreement with the Atomic Energy Commission, will include a betatron, a high voltage atom-smashing machine and special rooms for the storage and use of various types of radioactive materials.

Some of the rooms designed for radioactive substances must have walls of special construction as much as 3 feet thick, it was explained.

Recommend Increase in A.H.A. Membership Dues

CHICAGO.—The committee on structure of the American Hospital Association has recommended that association dues be increased in 1951, it was announced at association headquarters here following a meeting of the committee last month.

"The association ended the year of 1949 with a small deficit," the announcement said. "Inflation has increased prices over 50 per cent since 1943, when membership dues were last raised. The committee is recommending to the board of trustees that in view of the accomplishments in the last seven years and unmet needs which cannot be financed now dues be raised in 1951."

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NEWS...

Vanderwarker and Graham Win Northwestern Awards

CHICAGO. — Richard D. Vanderwarker, director of Passavant Memorial Hospital, was named this year's winner of the Malcolm T. MacEachern award in the hospital administration program at Northwestern University, it was announced by the university here last month. The award is made possible by the Johnson and Johnson Research Foundation and is given annually to the student who has achieved the highest standing in the hospital administration program, the announcement said.

Mr. Vanderwarker has been director of Passavant Hospital since 1947. Prior to that time he was manager of the Hotel Bellerive at Kansas City and, earlier, a member of the management staff of the Ambassador hotels in Chicago. He served in the navy for three years as a lieutenant commander.

Another Northwestern honor, the Mary H. McGaw award, went to Martha Elizabeth Graham, assistant administrator of People's Hospital, Akron, Ohio. The McGaw award is donated by Foster G. McGaw, president of the American



Martha Graham



Richard Vanderwarker

Hospital Supply Corporation, and is given annually to the student with the highest academic standing.

The Northwestern graduating class totaled 50 members, the announcement said, 42 in the master's degree course and eight who received the bachelor's degree in hospital administration at the university commencement last month.

N.J. Hospital Dedicated

CAMDEN, N.J. — The new Our Lady of Lourdes Hospital was opened at dedication ceremonies here last month and will be ready to receive the patients during July. Archbishop Thomas J. Walsh of Newark officiated at the dedication ceremonies for the \$4,500,000 362 bed structure.

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Marine Hospital, Buffalo, Turned Over to University for Chronic Disease Research

BUFFALO, N.Y. — The U.S. Marine Hospital, operated here for more than 40 years by the U.S. Public Health Service, was turned over to the University of Buffalo last month for operation as an Institute for Chronic Disease Research.

Speaking at ceremonies signaling the transfer, Dr. Herman E. Hilleboe, New York State Health Commissioner, stressed the growing importance of chronic disease as a public health problem. He explained that the institute would be operated by the university medical school with the cooperation of the medical profession, voluntary hospitals and other public and private health and welfare agencies in the community.

In another address, Federal Security Administrator Oscar R. Ewing said that the transfer "marks a real advance in necessary cooperation among federal, state and local governments."

"It is significant to turn this hospital over to this great university," Mr. Ewing said. "There is no politics in taking care of sick people. We all are interested in doing everything we can."

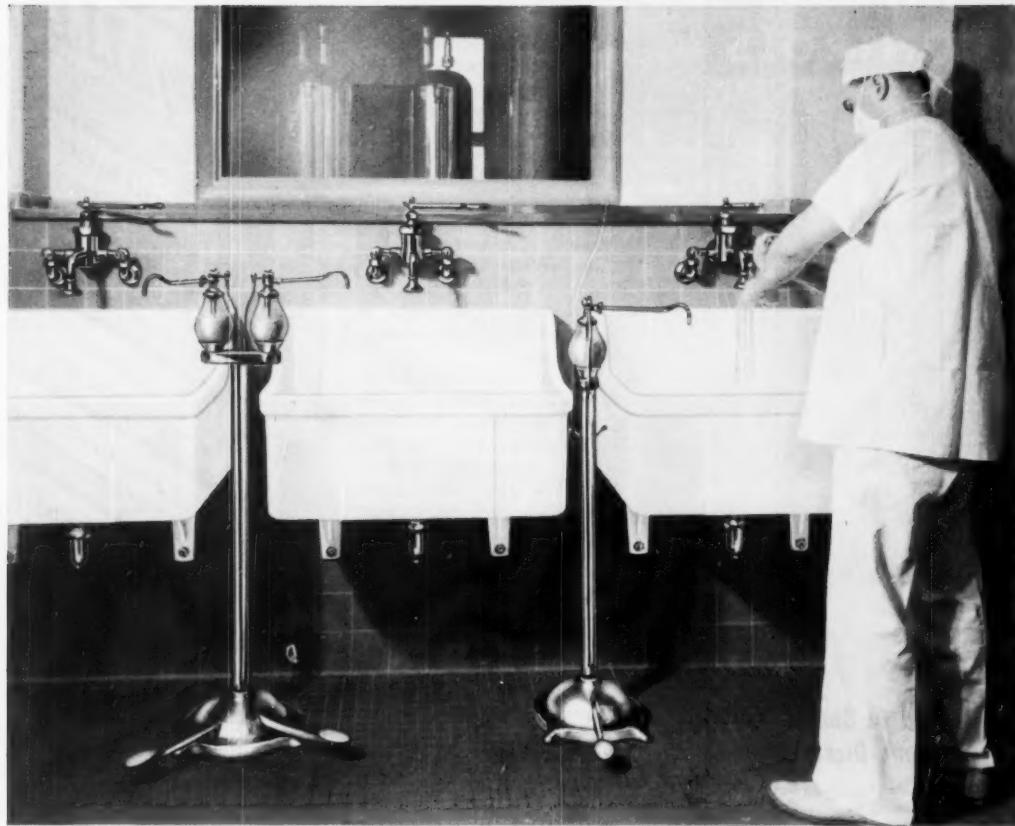
Blue Cross Membership Reaches 37,500,000

CHICAGO. — Membership in Blue Cross was approximately 37,500,000 in the United States and Canada at the end of the first quarter of 1950, Richard M. Jones, director of the Blue Cross Commission, announced here last month. Membership growth during the first quarter of the year was over 1,500,000—second highest quarterly enrollment in Blue Cross history, Mr. Jones said. There are now 90 plans operating, he added.

Enrollment of U.S. Steel and Bethlehem Steel employees under the national contract announced last March was named as a dominant factor in membership growth during the period. "Enrollment now represents 24 per cent of the United States population and 21 per cent of the population of Canada," Mr. Jones said.

The largest enrollment gain was reported by the Hospital Service Association of Pittsburgh, which added 221,000 members. Associated Hospital Service of New York reported 124,000 new members, and Plan for Hospital Care, Chicago, added 100,000, the report said.

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NEWS...

Social Security Bill Passed by Senate, Goes to Conference Committee

WASHINGTON, D.C. — A bill increasing federal social security benefits and adding 10,000,000 persons, including hospital employees, to those covered by social security was passed by the Senate June 20. The bill was sent into conference with the House, which approved a generally similar measure last year.

As they affect hospitals, provisions of the House and Senate versions of the bill were explained last month in a memorandum to hospitals from John H. Hayes, chairman of the council on government relations of the American Hospital Association.

"Some sort of coverage should be available for hospital employees within the reasonably near future," Mr. Hayes predicted. He explained that H.R. 6000 as passed by the House covers employees of all nonprofit organizations for old-age benefits and survivors' insurance under a provision which makes the employee contributions mandatory and the employer contribution optional.

As approved by the Senate finance committee and then sent to the Senate floor for action, the bill would make coverage optional for both employer and employee in the case of church organizations and government agencies. In this version, nonchurch institutions are covered under a provision making both employee and employer contributions mandatory, it was explained.

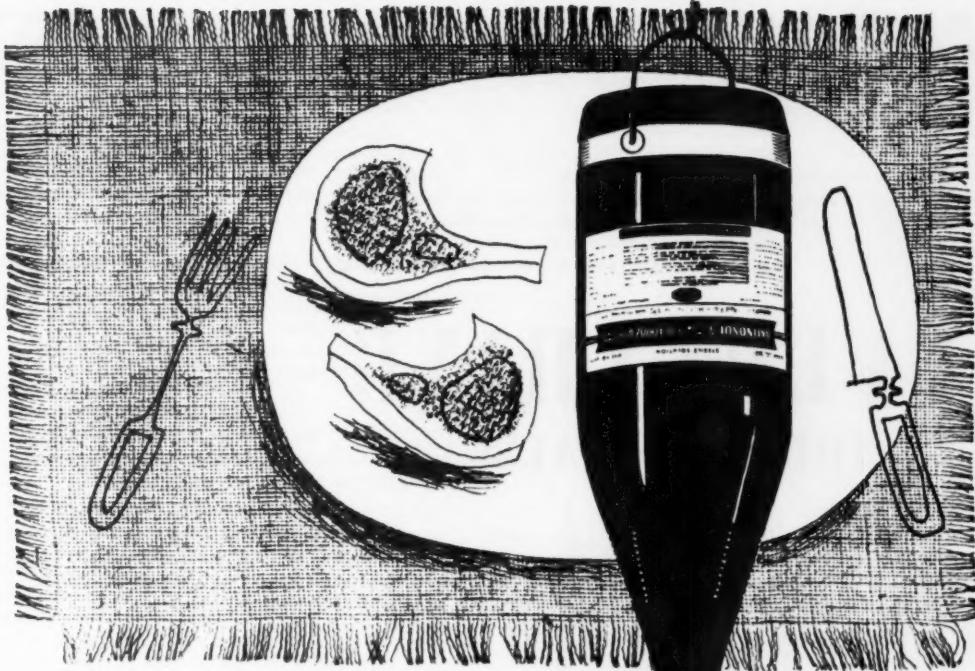
The provision separating church institutions from others was inserted by the Senate finance committee in response to expressions from groups which maintained that their inclusion on a mandatory basis might affect their tax-exempt status. The American Hospital Association took the position that federal social security deductions would not change tax-exempt status, Mr. Hayes added. However, he said, the separation of church from other nonprofit institutions, as provided in the Senate version, "in the future might easily become the basis for argument that church organizations are entitled to special privileges in tax exemption which are not extended to other nonprofit groups. This does seem serious."

As passed by the Senate, the bill calls for a 1½ per cent payroll tax on the first \$3600 of a year's pay. After 1955, the tax goes up to 2 per cent.

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NEWS...

A.M.A. Delegates Study Hess Report at San Francisco Convention

SAN FRANCISCO.—The Hess Report on hospitals and the practice of medicine was scheduled for full discussion by the House of Delegates as the 99th annual meeting of the American Medical Association met here June 26. Approximately 10,000 doctors attended.

The original Hess report, which recommended disciplinary action against

hospitals and medical schools judged guilty of "unethical practice of medicine" was adopted by the House of Delegates at Atlantic City a year ago. Following a recommendation by the association's board of trustees in November, the report was referred back to the committee. It was expected that full discussion of the recommended action on hospital

medical service would take place during the House of Delegates' meeting here.

The House also considered a report outlining plans for establishment of a student section of the association. The report has been approved by the executive committee of the board and aims at affiliating medical students and interns with the national professional organization. The delegates also studied reports of a survey on blood banks, looking toward establishment of a definite blood bank policy.

In one of the principal addresses, Dr. Ernest E. Irons of Chicago, who retired as association president, said physicians would continue their vigorous opposition to government proposal for a national health insurance system until "we shall have rolled back the Socialist flood that threatens to engulf our American freedom and our solvency."

Dr. Irons said that proponents of nationalized medicine had failed in their effort to accomplish this purpose in one move and were attempting instead to introduce "fragments of socialism" by means of small federal contributions to various welfare agencies. Opposition of the medical profession must include action against these "fringe bills," Dr. Irons declared.

In an unprecedented action, the association's House of Delegates seated Dr. Peter Murray of New York, first Negro member of the association's policy-making body. Spokesmen for the association pointed to the act as an example of what a physician can achieve under the free enterprise system.

Dr. Elmer Lee Henderson of Louisville assumed the presidency of the association and echoed the retiring president's opposition to government encroachment in medical fields. Dr. Henderson said American medicine has become "the blazing focal point in a fundamental struggle which may determine whether America remains free or whether we are to become a Socialist state."

Cortisone to Be Available to Hospitals in July, Manufacturer Announces

RAHWAY, N.J. — Cortisone will be available early in July to a large number of hospitals throughout the United States, it was announced here June 19 by Merck and Co., manufacturing chemists, who produce the drug by chemical synthesis.

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Long and extensive clinical experience in collaboration with the Blood Substitutes Subcommittee of the Committee on Medical Research of the National Research Council, has shown that this solution affords an effective nontoxic infusion colloid for use in shock management. It has been accepted by the American Medical Association's Council on Pharmacy and Chemistry.

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NEWS...

be supplied only to hospitals having certain minimum facilities operated by trained technicians and under the supervision of qualified physicians, the announcement said. Hospitals registered by the American Medical Association meet these requirements and are qualified to receive cortisone, which will be sold under the trade name, cortone.

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these institutions. This stipulation is considered essential for the present by the Food and Drug Administration.

Cortone will be delivered to these hospitals in packages of three vials, each vial containing 300 milligrams of the substance. The price to hospitals will be \$28.50 per vial, equivalent to \$95 per gram, the company stated.

Steadily increasing production of cortone and the accumulating knowledge concerning its use have made this limited distribution possible.

Need Integrated Action on Chronic Illness

CHICAGO.—Community-wide planning and action are needed to provide the answer to the nation's No. 1 health problem, care of chronic diseases, according to a report presented here last month at the second annual meeting of the National Commission on Chronic Illness. The commission is a joint product of the American Medical Association, American Hospital Association, American Public Welfare Association, and the American Public Health Association, it was explained.

Dr. Morton L. Levin, commission director, said that many states and cities have organized integrated programs for an attack on the chronic illness problem. The commission has recommended that each state, city and major community utilize existing agencies or establish widely representative planning groups to explore the many problems relating to the prevention and care of chronic illness. Leonard W. Mayo, chairman of the commission, said.

Dr. Levin reported that planning had been initiated by state legislative action in a number of states.

Red Cross Reorganizes Blood Bank Activities

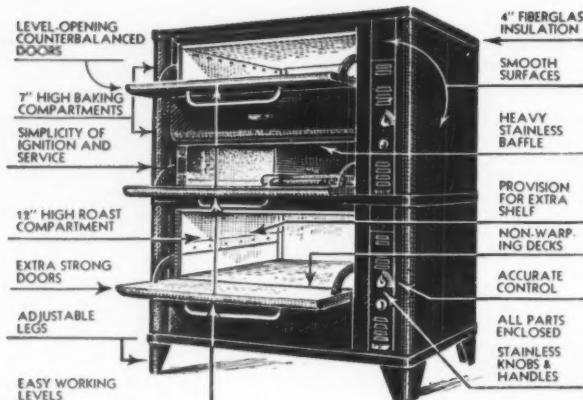
WASHINGTON, D.C.—Reorganization of blood bank activities of the American Red Cross was undertaken last month, it was announced here. The reorganization is aimed at rapid expansion of the program to provide for nationwide protection in event of disaster, it was explained.

The program is integrated with a far-reaching civilian defense plan being prepared by the National Security Resources Board, the announcement said. Approximately five years will be required to complete estimated needs for distribution facilities and stockpiling.

At present there are 32 regional Red Cross blood bank centers serving 800 communities and 1800 hospitals, the announcement said. These facilities serve approximately one-fourth of the national population. Among the organizations which will participate in the expanded program are the American Hospital Association, the American Public Health Association, American Medical Association, American College of Surgeons, American Society of Clinical Pathologists and American Pharmaceutical Association.

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• NOT a flavoring, NOT an ordinary condiment or seasoning, Ac'cent is a 99+ % pure monosodium glutamate in crystal form, a wholesome product of vegetable protein. Adding no flavor of its own, Ac'cent intensifies the natural flavors of foods, requires no change in regular recipes. Ac'cent is effective in many foods . . . meats, fowl, seafoods, gravies, soups, vegetables. Ac'cent also helps conserve flavors, combats "flavor-loss" through heating, waiting, serving.

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NEWS...

Five Universities Announce Appointments of Residents in Hospital Administration

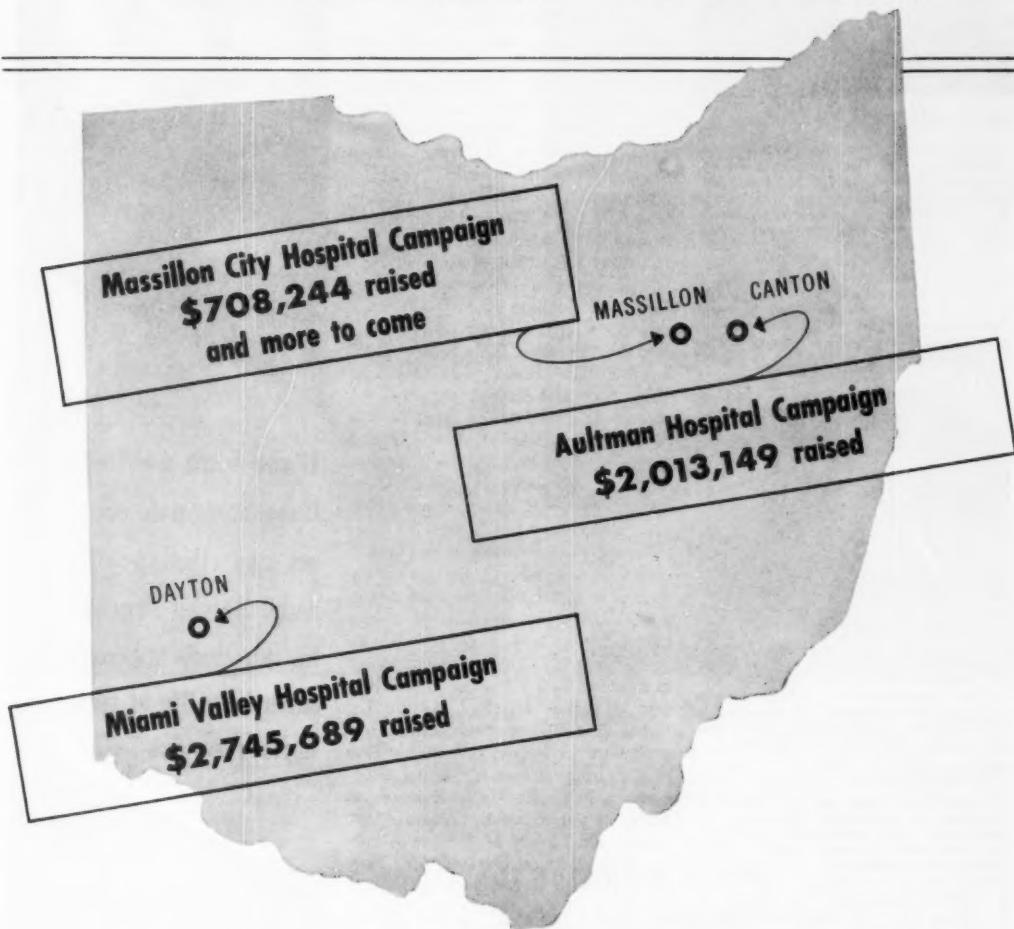
NEW HAVEN, CONN.—Residency appointments of members of the graduating class in hospital administration at Yale University were announced here last month by Dr. Clement C. Clay, director of the course. The appointments are as follows: Clarence W. Bushnell, to Massachusetts Memorial Hospitals, Boston; Elizabeth Jane Deckert, to Pittsfield General Hospital, Pittsfield, Mass.; John W. Gerdes, to Denver General Hospital, Denver; Malcolm C. Hope, to U. S. Public Health Service, Washington, D. C.; Adelaide E. Morris, to Whittaker Memorial Hospital, Newport News, Va.; Dr. Raul E. Palma, to Denver General Hospital; John J. Zugich, to University Hospital, Ann Arbor, Mich.

ST. PAUL.—Residency appointments of members of the graduating class in hospital administration at the University of Minnesota were announced here last month by James A. Stephan, assistant director of the course. The appointments are as follows: H. Gregg Armistage, to U. S. Navy Hospital, St. Albans, N. Y.; Sister M. Bernadine, to Holy Cross Hospital, Detroit; Harold E. Dale, to San Jose Hospital, San Jose, Calif.; Rudolph F. Elstad to Children's Hospital, San Francisco; Herman E. Hoche to U. S. Navy Hospital, Philadelphia; Thomas L. Hollis to U. S. Navy Hospital, Bethesda, Md.; William C. Hoppe to Good Samaritan Hospital, Portland, Ore.; Lloyd L. Hughes to Rhode Island Hospital, Providence.

Edward D. Irons to Hillcrest Memorial Hospital, Tulsa, Okla.; Oliver R. Johnson to Baylor Hospital, Dallas, Tex.; Norman L. Kaye to Charles T. Miller Hospital, St. Paul; Donald A. Kincaid to University of Minnesota Hospitals, Minneapolis; Dr. Marcelo G. Leite, to Denver General Hospital; Frederic C. Le Rocker to Vancouver (B.C.) General Hospital; James W. Mainguy to Council of Rochester Regional Hospitals, Inc.; Dale C. Mattison to St. Barnabas Hospital, Minneapolis; Russel H. Miller to Mary Hitchcock Memorial Hospital, Hanover, N. H.; Wade Mountz to Norton Memorial Infirmary, Louisville, Ky.

James R. Neely to Jersey City Medical Center, Jersey City, N. J.; John A. Nelson to Swedish Hospital, Minneapolis; Carl N. Platou to Northwestern Hospital, Minneapolis; Preston L. Powell to U. S. Navy Hospital, Pensacola, Fla.; Jack W. Rivall to St. Luke's Hos-

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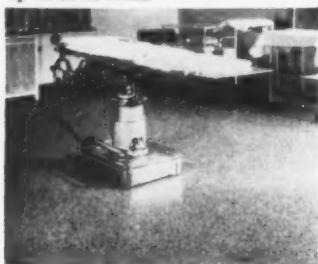
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For further reading, write for these reprints . . .
 Mallman, W. L., Michigan State College, 1941. A Bacteriologic Study of a New Sanogenic Flooring.
 Farrell, M. A. and Wolff, R. T., Penn. State College, 1941. Effect of Cupric Oxychloride Cement on Microorganisms.
 Researchers of Mellon Institute, American Chemical Society, Vol. 19 (1941). Hazard, Frank O., Wilmington College.
 Roach Repellent Cement.
 Jenkins, P. W., Sr Fellow, Mellon Institute. A Functional Floor Surface.

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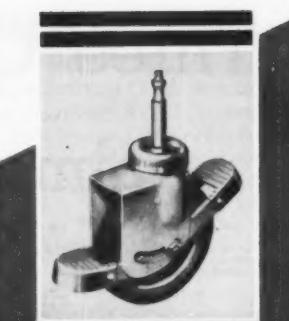
NEWS...

pital, Duluth; Clifford R. Rostomly to St. Luke's Hospital, Milwaukee; William H. Waite to Syracuse Memorial Hospital; Howard M. Winholz to University of Minnesota Hospitals.

CHICAGO.—Residency appointments of members of the graduating class in hospital administration at the University of Chicago were announced here last month by Ray E. Brown, director of the University Clinics. The appointments are as follows: Bernard Carr to Indiana University Medical Center, Indianapolis; James T. Googe Jr. to Bishop Clarkson Memorial Hospital, Omaha, Neb.; Joseph Greer to Baptist Hospital, Winston-Salem, N. C.; Victor Hernandez to Brooke Army Medical Center, Ft. Sam Houston, Tex.; Paul Hofstad to Norwegian-American Hospital, Chicago; Everett A. Johnson to Methodist Hospital, Gary, Ind.; Roger Klein to Cleveland City Hospital; Sam Ruth to Beth Israel Hospital, Boston; Edward A. Voss Jr. to Highland-Alameda County Institutions, Oakland, Calif.; Frank Walter to Graduate Hospital, University of Pennsylvania, Philadelphia; George Wren to Methodist Hospital, Indianapolis; Dr. David Zaugg, Marine Hospital, Staten Island, N.Y.

NEW YORK.—Residency appointments of members of the graduating class in hospital administration at Columbia University were announced here last month by Dr. John Gorrell, director of the program. The appointments are as follows: Paul J. Connor Jr. to Hartford Hospital, Hartford, Conn.; Dr. Curtis F. Culp, to Presbyterian Hospital, New York City; Leon W. du Flon to Mary Imogene Bassett Hospital, Cooperstown, N.Y.; Dr. Tulio Espinosa to school of public health, Columbia University; Dr. Edward M. Gordon to Public Health Service, Portland, Me.; Robert E. Heinlein to Muhlenberg Hospital, Plainfield, N. J.; Robert M. Jones to Columbia Hospital, Milwaukee; Marvin J. Lawrence to Jewish Hospital, Cincinnati; Sigifredo G. Martinez to University Hospital, New York City; John M. Nicklas to Lakeside Hospital, Cleveland.

Kurt H. Nork to New York Hospital; Harold C. Parks to Youngstown Hospital, Youngstown, Ohio; James R. Pepper to Harper Hospital, Detroit; Theodore D. Perkins to Freedmen's Hospital, Washington, D. C.; Richard E. Pieratt to St. Barnabas Hospital for Chronic Diseases, New York City; Wiley G. Poole to University of Pennsylvania,



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Armstrong's Greaseproof Asphalt Tile is particularly recommended for use in hospital kitchens and other areas where spilled oils or fats may present a floor problem. Its alkali resistance also makes it suitable for use on concrete subfloors which are in direct contact with the ground. Armstrong's Greaseproof Asphalt Tile is easy to keep neat and clean.

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NO single resilient floor is designed to meet all the flooring requirements of various hospital areas. Armstrong's Linotile is frequently used in lobbies and corridors because its unusual durability and beauty make it most practical for these areas. For private rooms and wards, the combination of moderate cost, long service, and colorful appearance makes Armstrong's Linoleum highly suitable. Armstrong's Cork Tile is recommended for areas where exceptional quiet is desirable. Concrete floors in direct contact with the ground present a special problem. The alkaline moisture in such subfloors is harmful to most flooring materials. Here, either Armstrong's Asphalt Tile or Arlon® Tile is needed since these floors are not affected by alkaline moisture. Before selecting any hospital floor, we suggest you call in your Armstrong Flooring Contractor. He can give you unbiased flooring recommendations.

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Vol. 75, No. 1, July 1950

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NEWS...

Philadelphia; Frank L. Porter III to Episcopal Hospital, Philadelphia; Dr. Alfonso Ramirez to Morrisania Hospital, New York City.

J. Emerson Robinson to University of Pennsylvania, Philadelphia; Frederick C. Sage to Stanford University Hospitals, San Francisco; Robert E. Sleight to Springfield Hospital, Springfield, Mass.; Robert D. Stout to University Hospital, Baltimore; Robert E. Toomey to the Hospital Council of New York; Donald E. Walchenbach to

Lowell General Hospital, Lowell, Mass.; Henry J. Whyte to Freedmen's Hospital, Washington, D. C.

CHICAGO.—Residency appointments of members of the graduating class in hospital administration at Northwestern University were announced here last month by Dr. Malcolm T. MacEachern, director. The Northwestern appointments are:

Henry Amicarella to Colorado General Hospital, Denver; Nils G. Axelson to East Orange General Hospital, East

Orange, N. J.; John J. Bale to Reading Hospital, Reading, Pa.; Norma Barden to Philadelphia General Hospital; George T. Brotherton to Methodist Hospital, Dallas, Tex.; Benny T. Carlisle to Baylor University Hospital, Dallas, Tex.; Marian F. Cipala to Jefferson-Hillman Hospital, Birmingham, Ala.; Paul F. Detrick to Bethany Hospital, Kansas City, Kan.; James E. Ferguson to East Tennessee Tuberculosis Hospital, Knoxville.

John C. Gettman to Memorial Hospital, Fremont, Ohio; Dwayne L. Hall to Waverly Hills Sanatorium, Waverly Hills, Ky.; Waldo A. Hill to Baylor University Hospital, Dallas; Robert T. Jacobson to Baroness Erlanger Hospital, Chattanooga, Tenn.; Joseph A. Lilli to Montefiore Hospital, Pittsburgh; Raymond T. McHugh to Herrick Memorial Hospital, Berkeley, Calif.; Freeman May to Baptist Memorial Hospital, Memphis, Tenn.; Kenneth D. Moburg to Grace Hospital, Detroit; George D. Monardo to Los Angeles County, Los Angeles; Marvin W. Nichols to Methodist Hospital, Sioux City, Iowa.

Albin H. Oberg to Malden Hospital, Malden, Mass.; James W. Quinn to Jefferson-Hillman Hospital, Birmingham, Ala.; Ernest W. Quittmeyer to Passavant Memorial Hospital, Chicago; Robert A. Sandahl to Milwaukee County Institutions; Donald F. Scalzo to Grant Hospital, Chicago; Richard L. Sejnost to Harper Hospital, Detroit; Carlos J. R. Smith to Methodist Hospital, Memphis, Tenn.; Proctor L. Waldo to Wesley Memorial Hospital, Chicago; Ned W. Wickham to Druid City Hospital, Tuscaloosa, Ala.

Announces Plan for Renting X-Ray Equipment

MILWAUKEE, WIS.—A plan under which hospitals and doctors may obtain x-ray equipment on a rental basis was announced here last month by the General Electric X-Ray Corporation. The plan, which was described by company officials as the first program of its kind in the field of medical x-ray, was designed to assist hospitals and other institutions and individuals for whom a major capital investment in x-ray equipment would be a burden.

Under the program, hospitals may select and install equipment and contract for its maintenance, including tube replacement and other repair and replacement parts, for a fixed monthly charge, it was explained.

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Manufactured for use with Oxygen, Oxygen-CO₂ Mixtures and other gases, Liquid pressure-reducing regulators accurately control the gas flow from cylinders at the rate specified. When ordering, mention gas to be used. Liquid regulators are available in five models with dial or tube gauges that register pounds per square inch or liters of flow per minute.

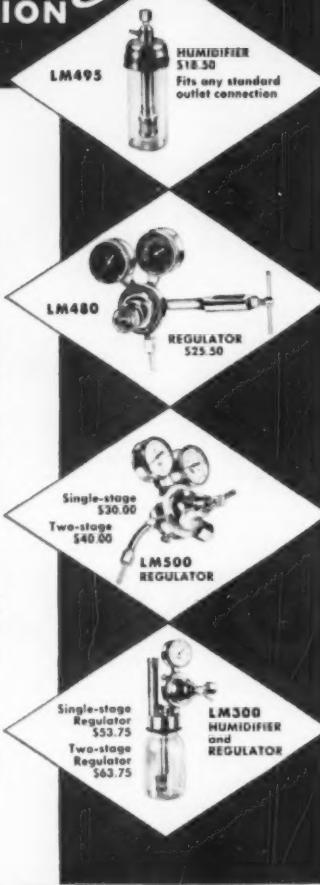
Also a complete line of endotracheal equipment.

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GLOMANGIOMA-LEFT:
This reproduction shows how effectively color may be used to present the over-all preoperative aspect of a case. **RIGHT:** Color demonstrates effectively the essential details of the surgical specimen. (From Kodachrome transparencies.)

One No. 5 flash lamp in flashholder at camera lens is synchronized with shutter.



Picture the patient in color...for study, reference, and teaching

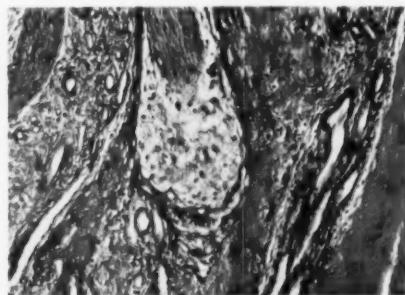
INSTEAD OF relying upon sketches and notes, with occasional photographs, physicians in more and more hospitals, clinics, and private offices are emphasizing the use of photography as a routine procedure . . . concentrating, for the most part, upon full color. For color "sees" as the eye sees—realistically . . . registers visual impressions as notes and memory never can.

For example, see how graphically color presents details in these illustrations . . . what a positive basis it provides for research, reference, and teaching.

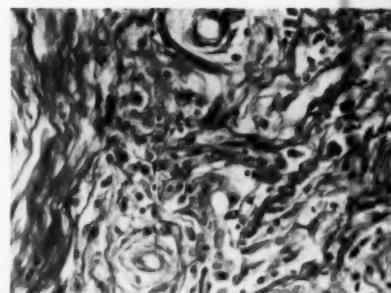
Equipment needed? Merely a camera with color-corrected lens, simple lighting equipment, a supply of Kodak color film—Kodachrome or Ektachrome.



1



2



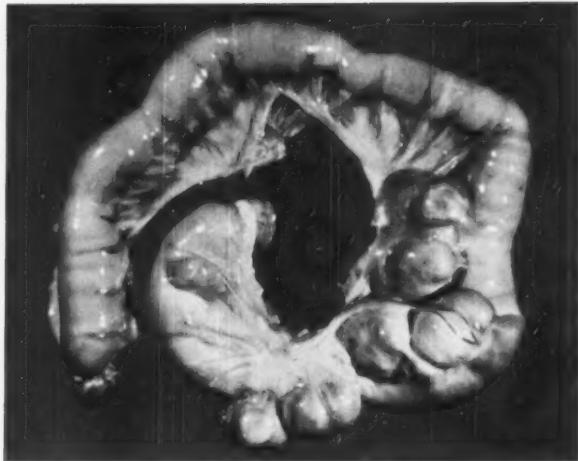
3

GLOMANGIOMA: Microscopic appearance of sections made from the specimen illustrated at top of page (right) is revealed in the three photomicrographs displayed at the left and above—(1) and (2) $\times 80$; (3) $\times 260$. (From Kodachrome transparencies.)

Serving medical progress through Photography and Radiography

Kodak
TRADE-MARK

Picture the patient (continued)



MULTIPLE DIVERTICULA OF THE JEJUNUM (ABOVE): Reproduction demonstrates the value of color in showing the character and extent of an anomaly. (From a Kodachrome transparency.)

LEFT: Setup of camera components of Kodak Flurolite Enlarger for the photography of gross specimens. Complete details of setup and equipment are available upon request. Write to Eastman Kodak Company, Medical Division, Rochester 4, N. Y.

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ANY CAMERA with a color-corrected lens is a "color camera" once it's loaded with full-color Kodak Film—Kodachrome or Ektachrome. No special equipment is required . . . no special technic needed for the exposure.

IF YOU USE KODACHROME FILM, Kodak will do the processing for you (cost included in price of film). Duplicates (same size, enlarged, or reduced) and Kodachrome Prints are available through dealers.

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For further information, see your dealer . . . or write to Eastman Kodak Co., Medical Division, Rochester 4, N. Y.

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NEWS...

President Names Committee to Study V.A. Problems

WASHINGTON, D.C.—A special committee to study hospitalization problems of the Veterans Administration was named here last month by President Truman following public protests by congressmen and veterans' organizations against the closing of a V.A. hospital at Van Nuys, Calif.

Members of the committee named by the President were Dr. Howard A. Rusk, chairman of the department of physical

medicine and rehabilitation at New York University-Bellevue Medical Center, Dr. Arthur Abramson, head of the department of physical medicine and rehabilitation at the Veterans Administration Hospital in the Bronx, N.Y., and R./Adm. Robert L. Dennison, naval aide to the President.

The committee will make a special study of the problems of paraplegics and amputees, the announcement said. Transfer of paraplegics from the Birmingham General Hospital at Van Nuys occa-

sioned much of the criticism by veterans' organizations and congressmen, it was explained.

The President indicated the committee was created "in order to provide clarification of existing hospitalization problems and needs of disabled veterans." The committee had been authorized to call in consultants and specialists as needed and will report its findings directly to the President, it was explained.

Teachers College Sponsors Nursing Conference

PLYMOUTH, N.H.—A national nursing conference sponsored by the division of nursing education of Teachers College, Columbia University, met here last month in an effort to develop regional coordination and cooperative planning for nursing and nursing education in the United States. Dr. R. Louise McManus, director of the division, said that the conference was the first such attempt that had been made in this country; the conference was related to current health and medical programs in the nation and attended by leading nursing officials and educators, she stated.

Dr. Gordon Blackwell, director of the institute of research and social studies at the University of North Carolina, was general chairman of the conference. The educational phases of the study were supervised by Hortense Hilbert of the Teachers College nursing staff.

The purpose of the conference was to explore problems, methods and materials for regional cooperation among nurses and in the nursing field generally, it was explained. "Several groups of planners have been considering some of the problems of education for the health services in the nation," Dr. McManus stated, "but to date little has been done to include nursing in this planning."

Open Community Hospital

KINGFISHER, OKLA.—The new Kingfisher Community Hospital was formally opened here last month with dedication ceremonies followed by an open house during which residents of Kingfisher County were invited to inspect their new hospital facilities. The hospital has 21 beds and was built under Public Law 725 at a total cost of approximately \$165,000.

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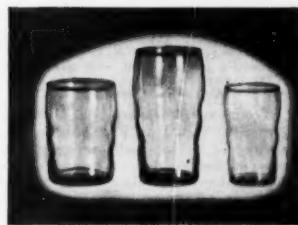
A single Heat-Treated tumbler falling. Stroboscopic photograph catches 17 images, as it drops—and bounces!

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You make big savings for your hospital by equipping it 100% with Libbey Heat-Treated Safedge tumblers.

Here's how you gain. Libbey Heat-Treated tumblers last from 3 to 5 times longer than ordinary tumblers. That means fewer replacements. Smaller inventory. Less time lost cleaning up. And they stand sterilization better than ordinary glasses, too.

Patients and staff like their thinness, lightness and the smooth, rounded "Safedge." Also, they are covered by the famous Libbey "Safedge" guarantee—a new glass if a rim ever chips. In fact, you gain in every way by equipping your hospital with Libbey Heat-Treated glasses. Ask your supplier for samples and prices—or write us direct if you prefer.



3 sizes: 9½ oz. (water), 12 oz. (iced tea), 5 oz. (juice). All Heat-Treated for extra strength.

LIBBEY GLASS BOUNCE TUMBLERS

Libbey Glass, Division of Owens-Illinois Glass Company, Toledo 1, Ohio



NEWS...

Catholic Convention Studies Special Problems

(Continued From Page 85.)

Speaking for hospitals, George Bugbee of the American Hospital Association repeated the text of the resolution on hospitals and the practice of medicine adopted recently by the board of trustees of the association. He said the public has no interest in or patience with the argument between a small group of specialists and hospitals. It is neither illegal nor unethical for the in-

come of a hospital medical department to exceed its cost, Mr. Bugbee said. He pointed out that in a recent survey of physicians' incomes, radiologists enjoyed the highest average of any of the specialties. Mr. Bugbee suggested that if it could be judged that \$4 of a \$10 laboratory charge constituted adequate compensation for the pathologist, in view of his special training and professional competence, and if another \$4 covered all costs to the hospital, it might be wiser to return the remaining \$2 to the

patient in the form of a reduced charge instead of allowing a surplus to accrue to either the hospital or the specialist.

E. A. van Steenwyk, director of Associated Hospital Service of Philadelphia, presented the consumer's standpoint. Said Mr. van Steenwyk: "The consumer is unalterably opposed to the fragmentation of his medical bill. He wants to pay a single bill, through insurance, and he expects doctors and hospitals to work in harmony with insurance plans to make this possible." Mr. van Steenwyk brought out the fact that insurance requires a broader view of hospital and medical economics than is suggested when each particular charge for each item of service may vary in accordance with the desire of those providing the service. He warned that the spectre of empty hospital beds, a high percentage of indigent patients, and economically depressed hospitals and doctors haunts medical economics.

The argument between radiologists, pathologists, anesthesiologists, and hospital administrators as to who is to bill the patient and how the bill shall be split up is of no interest to the public, Mr. van Steenwyk declared. In fact, patients are getting increasingly critical of hospitals and doctors, he said, and are insisting that the arguments be settled so that the patient can pay one bill—his insurance premium. The consumer wants more and not less insurance coverage for complete hospital and medical care. He concluded: "The choice is not between insurance and individual responsibility for medical care. The choice is between voluntary and compulsory government insurance."

One of the best attended section meetings at the convention was concerned with the patient's safety. Opening the discussion at this session, Chief Edward E. Wischer of the Milwaukee Fire Department said, "If any of you were to ask me what my greatest concern is as the chief of the Milwaukee Fire Department, I would毫不犹豫ly say, 'the patients in our hospitals and institutions.' The several recent disastrous fires have as you know resulted in a concentrated survey of fire hazards in hospitals all over the country." These surveys show conclusively that conditions in many older hospitals make repeated tragedies possible, Chief Wischer pointed out. Local fire chiefs are always ready and willing to help hospitals plan for fire safety, he said. Automatic sprinkler protection is recommended for

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WITH FEATURES
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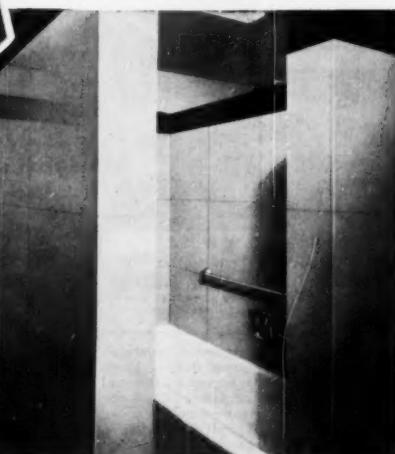


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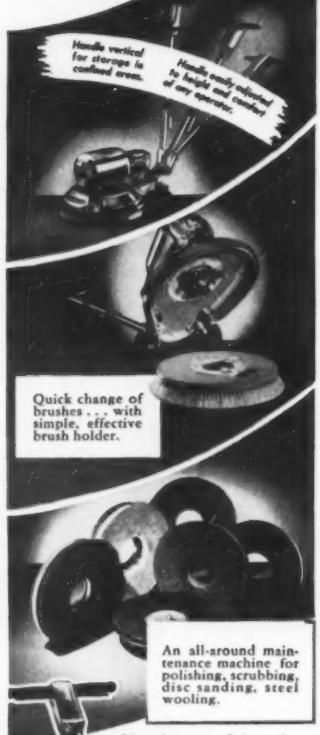
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NEWS...

all hospital areas, the chief stated. Such protection is an absolute "must" in older, nonfireproof hospital buildings, he added.

One general assembly was devoted to the theme, "The Catholicity of the Catholic Hospital." Msgr. Maurice F. Griffin, past president of the association, presided at this session. Rev. James V. Moscow, assistant director of hospitals, Archdiocese of Chicago, pointed out that while Catholic hospitals can adopt most of the technical and management proficiencies worked out by lay hospital and health experts, before a Catholic hospital accepts any procedure—whether it be accounting, fund raising, admission policies, collection methods, or public relations—it must first "Christ process it," or, in other words, Catholicize it.

First let us promulgate positively by teaching and example the precious treasure we profess to live and have exclusively to offer—Christ's way of life, the Rev. Moscow said. We must be zealous in promoting our technical and material progress, he said, but never at the sacrifice of Christ-like principle.

Father Moscow warned against enlarging hospitals just to keep pace with the popular trend. "We may reason that if we build now we can get federal aid, even though we must go deeply in debt ourselves, and that if we don't act now, the community hospital in this adjoining town will get the aid," he argued. "Don't misunderstand me, Sisters, it is noble and fine to want to build if the community you serve needs more beds, but let us not forget that in our plans should also be the consideration that we must be able to continue after expansion to give true Catholic service. If the extra debt is going to make us too money conscious, and if the expansion is going to mean spreading the Sisters or Brothers so thin that the patient seldom sees one, or if Sisters are so scarce that they cannot visit the sick or meet the public in key positions, or if you are so busy that you have no time to hand pick and train lay substitutes for such positions, is our hospital going to be as completely Catholic as Christ would want it?"

Sister John of the Cross, director of nursing service at St. Vincent's Hospital, Portland, Ore., urged that printed or mimeographed matter devoted to Catholic practices be inserted in each intern's manual and in each nurse's procedure book. Such information sheets, she said, should be distributed to each

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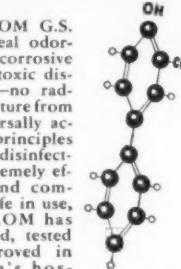


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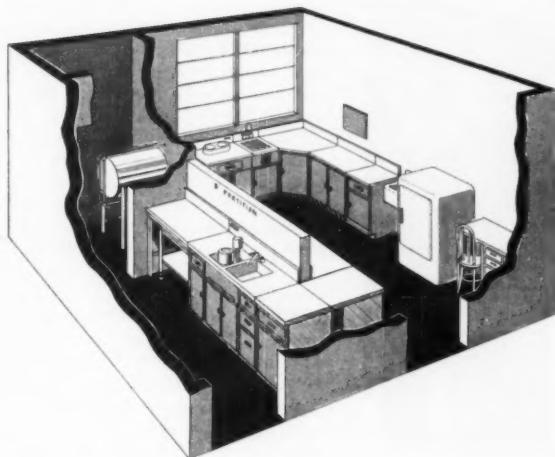
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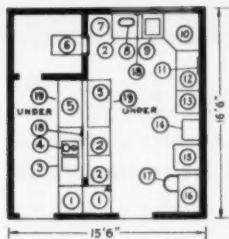
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Vol. 75, No. 1, July 1950



NEWS...

floor and to every department, including social service and outpatient clinics. "Only through the printed and spoken word can we lead all personnel from the floor mopper to the top surgeon to not just see the sick, but to see Christ in the sick and to go ahead under Catholic directives for the maximum care of the patient, physically, mentally and spiritually," Sister John said.

His Eminence Samuel Cardinal Stritch, Archbishop of Chicago, in the opening address of the convention said

that the medical profession has not faced squarely the problem of adequate medical care for all. "We face today the problem of fitting adequate medical care into the lives of the middle class group," said Cardinal Stritch. "We cannot solve this problem by simply condemning governmental regimentation. All the arguments we have put forward against compulsory medical care are well balanced enough, but we must still find a way to provide sane and reasonable assistance from public authorities with-

out the tone of the present compulsory, all-inclusive, federal proposals. I am afraid that the medical profession has not faced as squarely as it should this commanding social problem."

Msgr. John Barrett, president of the association, condemned the concept that only the federal government through compulsory health legislation can solve the problem. He said the Catholic group believes that voluntary organizations and private initiative, backed by government financial support, can and will solve the problem of furnishing high-grade medical and hospital care to all at a price within reach.

Msgr. Robert A. Maher, vice chairman of the association's administrative board, summarized the action of that group. He stated: (1) Catholic hospitals are being fairly treated under Public Law 725; (2) it seems almost certain that Catholic hospitals will be included under the revision of our social security laws; (3) it doesn't look at present as though the federal bill for aid to medical and nursing education would be passed by this Congress; (4) the Catholic group is pressing forward on the important problem of full cost payments for the care of indigent patients.

A sectional meeting on Catholic admission policy followed the theme, "How can Catholic hospitals maintain the Catholic spirit of charity and still balance the budget?" Sister Kathleen Parris, business manager at St. Vincent's Hospital, Toledo, pointed out that the admitting officer must inspire confidence toward the hospital in the patient's mind and added that a sound, well organized, friendly admitting procedure makes the job of the credit and collection officer much easier. She urged that in all cases the ability of the patient to pay for the type of accommodation selected be determined before the patient is actually admitted. Charity allowances must be conserved for the truly needy, said Sister Kathleen. Sister Mary Eileen, administrator, Mercy Hospital, Cedar Rapids, Iowa, said the hospital credit policy must also be flexible. No person really requiring immediate admission to the hospital as determined by a physician should ever be turned away because he could not pay an advance bill or find someone to guarantee the account, she declared.

The Rev. Clement G. Schindler, Diocesan Director of Catholic Hospitals, East St. Louis, Ill., suggested that true charity means making a careful study



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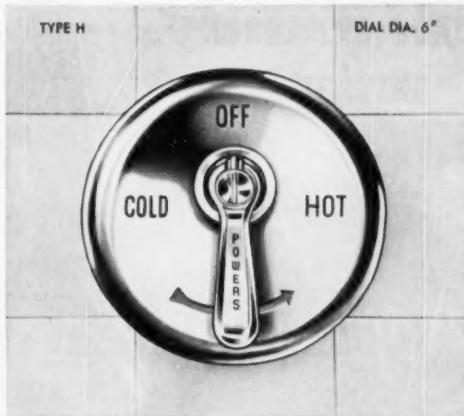
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NEWS...

of each patient's paying ability and then working out a fair payment plan for each. We are doing an injustice rather than performing a Christian act of charity when we fail to collect from patients who can and should pay the full cost of their care, he asserted. He warned hospitals of a steadily increasing drive to take away tax exemption unless a reasonable amount of free work is done. Catholic hospitals must estimate the value of the Sisters' services on the basis of the salary that equivalent work-

ers would receive and then let the public know just how many thousands of dollars this service represents, as the Sisters' charitable contribution to the hospital care of the community, he said.

Every administrator knows that the hospital which can claim a sizable, successful and popular auxiliary has received an indisputable seal of public approval, according to Sister Martha Mary of St. Clare's Hospital, New York City. The subjects of gift shops, coffee shops, visitors' guides and aids, informa-

tion clerks, and many other projects opened to auxiliary groups were thoroughly discussed at a session on volunteer projects.

Surgeon General Leonard A. Scheele of the Public Health Service told a general assembly that the fabric of American life is the life of the neighborhood community, and no other community institution so fully expresses the impulse to be a good neighbor as does the hospital. The nation's small but growing experience with regional hospital organization and planning, Dr. Scheele said, is the distinct contribution of voluntary hospitals and a few private foundations. The sooner we increase that experience, he added, the sooner hospitals and their communities will have direct evidence of the benefits of regional planning and organized services. The Surgeon General pointed out that small institutions, especially those in small communities, cannot provide complete service within their own walls. "How can the quality of service be raised in ill-equipped, inadequately staffed hospitals?" he asked. "Up to the present time the trend toward regional planning and organization of services is terribly slow. No state plan is perfect, I am sure, and some leave much to be desired, but it is discouraging that many hospitals and communities are not even cooperating with their state agency in abiding by the plan approved by the state advisory council for the location and construction of facilities."

No Catholic hospital in these days can consider itself an entirely independent unit and overlook its relationship to the other Catholic hospitals in the diocese and to all hospitals in the area, the Rev. Francis P. Lively of Brooklyn warned. It seems to be a common failing in Catholic hospitals, Father Lively said, to have a small, select group, and not infrequently a single doctor, dominate the entire staff for a long period of years. He urged the allocation of staff appointments for doctors in Catholic hospitals on an equitable basis to prevent a few doctors from having choice appointments in several institutions where others have no affiliation at all. Father Lively also urged cooperation in nursing education, so that central schools of nursing could economize on faculty time, and cooperation among Catholic hospitals in training technicians. One hospital in a region could train record librarians, another laboratory technicians, and so on, he suggested.



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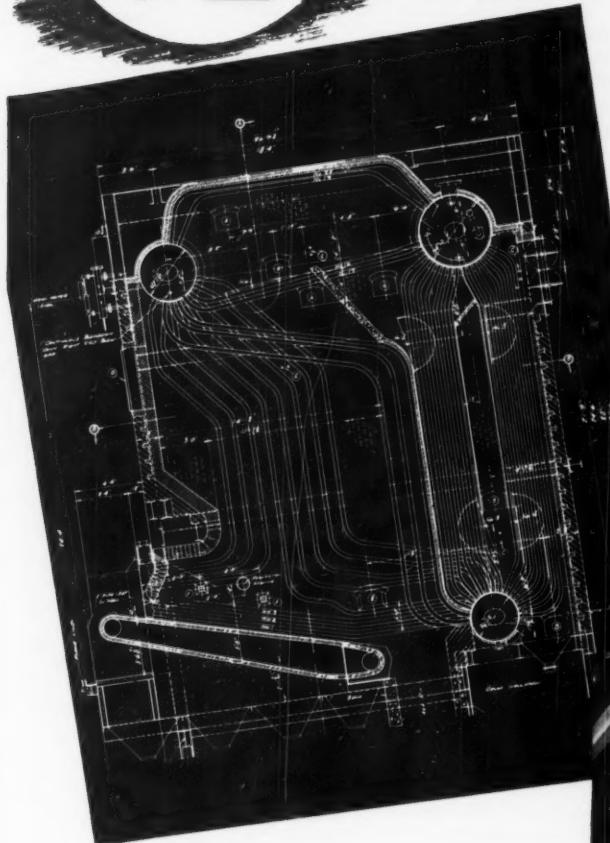
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NEWS...

Mary E. Switzer, assistant to the Federal Security Administrator, spoke about Sisterhood planning. In this period when more and more responsibility has been assumed by the government, state and local as well as federal, there has been a growing concern about how community effort and responsibility can be stimulated and whether the traditional pattern of our voluntary institutions in the field of health and welfare can meet current needs in the field, Miss Switzer said. As running the hospital becomes

more and more a task for the administrator, the fiscal agent and the highly specialized technical staff, the ideal of personal service can be submerged, she warned. The distinctive characteristics of our nursing Sisterhoods could become so diluted in this process as no longer to be an important influence in the care of the sick, Miss Switzer said. She urged Catholic groups to study particularly the problems of opening hospitals in places where most groups fear to make the effort.

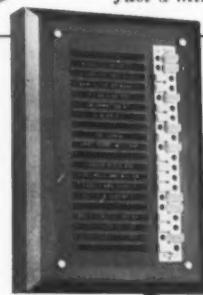
"It takes daring to move into a community poorly served, full of prejudices, jealous of being far behind much of the nation," Miss Switzer stated. "It takes dedication not only to bring to such a setting modern medicine and health care but, through giving of service, to rouse our compassion for our sick neighbors and our determination to make sacrifices to bring them what they need."

Sister Bernadine, administrator of St. Elizabeth's Hospital, Drayton, N.D., discussed the difficulties encountered in operating her small general hospital of approximately 20 beds. She pointed out that employees in such a small hospital must be versatile and trained in many jobs. She emphasized the fact that only through allying her hospital with larger institutions in the area could she be certain that the patients in her hospital would get adequate medical services.

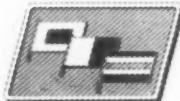
Dr. Louis Block, deputy chief, Division of Hospital and Medical Resources, U.S. Public Health Service, pointed out that the hospital coordination program is only a means of bringing services and resources to all the people within a hospital area. Coordination, he said, must of necessity be achieved, and a continuing program of public education as to the true meaning of a co-ordinated hospital system must be carried out.

George Hendrix, chief, division of construction and services, Illinois State Department of Health, stressed the fact that the size of a hospital should be measured in terms of its ability to serve its patients and not by bed count. Illinois, he said, will build no hospitals fewer than 50 beds under P. L. 725, feeling that a 50 bed hospital is the smallest size in which reasonably well rounded service can be achieved. Even 50 bed hospitals must make some arrangement with larger hospitals in the area for consulting services, Mr. Hendrix added.

In his induction speech as president of the association, The Right Reverend Monsignor John R. Mulroy of Denver paid high tribute to the fine work of Msgr. Barrett of Chicago, the retiring president. Outlining what seemed to him to be the primary interest of the Catholic group, Msgr. Mulroy stressed the importance of in-service training in the form of institutes, workshops and the like for all people concerned with the operation of a hospital. He urged Sister administrators to attend such in-



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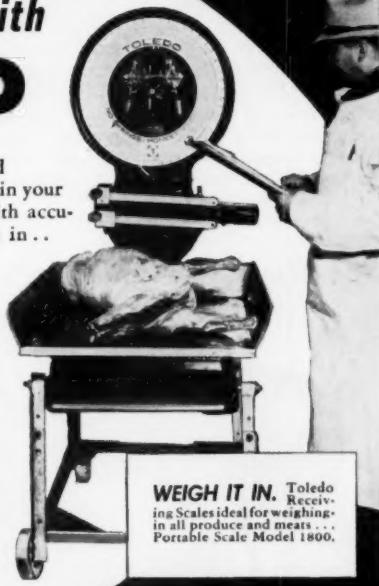
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NEWS...

stitutes and to send their department heads. A serious challenge to the Catholicity of our hospitals has arisen from the difficulty of maintaining a personal and spiritual interest in the welfare of each patient as a human being, Father Mulroy said. "We must catch up with scientific progress and, without being obtrusive, bring the Catholicity of our hospitals to the foreground. Because they are Catholic, our hospitals must be human institutions. We must be interested in each patient's life and

problem—his family, if need be," he concluded. Msgr. Mulroy urged all the Catholic Sister groups to interest themselves in the care of the chronically ill, the aged, the mental and the tuberculous.

Commenting on attendance at the exhibits, one exhibitor expressed the feeling of many when he said, "I wish the delegates to all hospital meetings would spend as much time and give as much thought and attention to the exhibits as do the Catholic Sisters attending these

annual meetings of the Catholic Hospital Association."

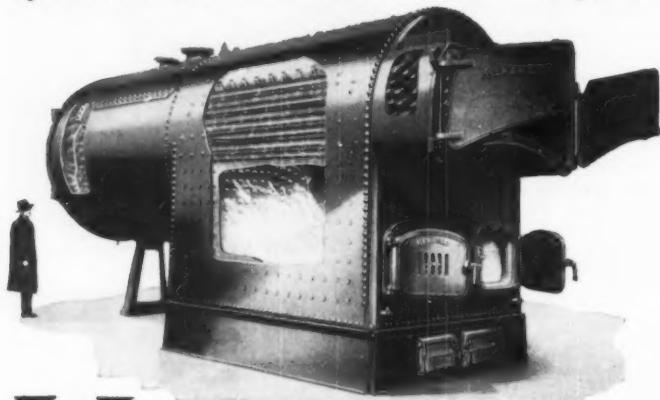
Montefiore Hospital Opens Division of Social Medicine

NEW YORK.—A division of social medicine has been established at the Montefiore Hospital here, Dr. E. M. Bluestone, hospital director, announced last month. The division is on a par with clinical and laboratory divisions of the hospital staff, Dr. Bluestone said. The entire staff is on a full-time basis, it was explained.

Dr. Martin Cherkasky has been appointed chief of the social medicine division, which will include the hospital's social service departments and will also direct operation of the home care program, a group practice unit operated in affiliation with the Health Insurance Plan of New York, and a new "health maintenance center."

The health maintenance center is a new project sponsored jointly by the hospital, Columbia University College of Physicians and Surgeons and the Community Service Society. The project will select 500 New York families as subjects of a "study in detail" of family health, it was explained. The center will direct programs concerned with physical ailments, preventive medicine and social problems presented by the subject families. The health maintenance center was described by Dr. Bluestone and Stanley Davies, director of Community Service Society, as "a frontal attack on the problem of preventing, rather than curing, disease through the combined forces of clinical medicine, social work, psychology, psychiatry and education." It will be undertaken in September, the announcement said.

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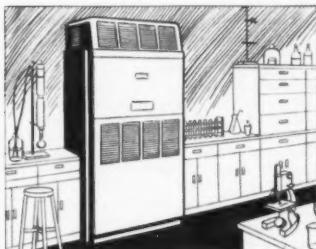
Stages Health Parade

NEW YORK.—In a unique fund-raising effort, the Mount Morris Hospital of Harlem staged a "Harlem Health Parade" here last month. The parade was a feature of the Negro hospital's drive to raise \$100,000 needed to complete expansion of its facilities to 100 beds.

Many of the government and social service agencies active in Harlem participated in the parade, which included units and floats symbolic of various health problems and activities in the community.

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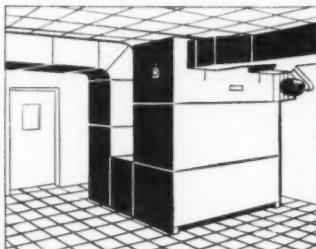


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NEWS...

Middle Atlantic Assembly Meets in Buffalo

(Continued From Page 130.)

hospital system. As he has done at regional hospital meetings throughout the country in recent months, Mr. Hatfield urged coordinated planning among the various federal, state, local and voluntary agencies concerned with hospital care of the public.

In another presentation at this session, Dr. Herman E. Hilleboe, New York state health commissioner, warned

against the concentration of government hospital resources in a comparatively small number of large institutions. Rather, he suggested, public funds could be used more effectively through wider distribution among smaller institutions doing equally important work.

Special problems of safety, hospital insurance, communicable disease care and hospital association activity were discussed at the final session of the general assembly, while these and other phases of hospital operation were re-

viewed by speakers at the morning sessions of the state hospital associations. During the assembly, the following officers were elected by the participating state associations:

NEW YORK STATE ASSOCIATION: president: Carl P. Wright Jr., Utica; vice presidents: F. Wilson Keller, New York, and Dorothy Pellenz, Syracuse; secretary: Carl P. Wright Sr., Syracuse; treasurer: Moir P. Tanner, Buffalo.

Trustees: Bernard McDermott, Brooklyn; Vernon A. Reed, Buffalo; John H. Hayes, New York; William G. Illinger, White Plains; and Marian Sawtell, Binghamton.

PENNSYLVANIA ASSOCIATION: president: Alma M. Troxell, Oil City; vice presidents: E. Atwood Jacobs, Reading, and Sister M. Adele, Pittsburgh; treasurer: Robert W. Gloman, Wilkes-Barre.

Trustees: Jane J. Boyd, Butler; George A. Hay, Philadelphia; William E. Barron, Pittsburgh; and J. Hamilton Chester, Philadelphia.

NEW JERSEY ASSOCIATION: president: Anthony W. Eckert, Perth Amboy; president-elect: W. Malcolm MacLeod, Elizabeth; vice president: William B. Meyrott, Trenton; treasurer: Howard S. Lyon, Somerville; executive director: J. Harold Johnston, Trenton. Trustees: William L. Chapman, Hackensack; and Sister Claire Dolores, Montclair.

COMING MEETINGS

AMERICAN ASSOCIATION OF BLOOD BANKS, Stevens Hotel, Chicago, Oct. 12-14.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Somerset Hotel, Boston, Oct. 22-27.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Ritz-Carlton Hotel, Atlantic City, Sept. 18-21.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Traymore Hotel, Atlantic City, Sept. 17, 18.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, MIDWEST INSTITUTE FOR HOSPITAL ADMINISTRATORS, Boulder, Colo., Aug. 14-19. **INSTITUTE FOR HOSPITAL ADMINISTRATORS,** International House, Chicago, Sept. 5-15; **FELLOWS' SEMINAR,** University of Chicago, Dec. 13-16.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Hotel Statler, Boston, Aug. 28-Sept. 1.

AMERICAN HOSPITAL ASSOCIATION, Atlantic City, Sept. 18-21.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Colorado Hotel, Glenwood Springs, Colo.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Lord Baltimore Hotel, Baltimore, Oct. 30, 31.

MICHIGAN HOSPITAL ASSOCIATION, Statler Hotel, Detroit, Nov. 12-14.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 30-Nov. 1.

WASHINGTON STATE HOSPITAL ASSOCIATION, Davenport Hotel, Spokane, Sept. 7, 8.

1951

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Congress Hotel, Chicago, March 1, 2.

ASSOCIATION OF METHODIST HOSPITALS, Congress Hotel, Chicago, Feb. 28-March 1.

SOUTHEASTERN HOSPITAL CONFERENCE, St. Petersburg, Fla., April 3-5.

SOUTHWIDE BAPTIST HOSPITAL ASSOCIATION, COMMISSION OF BENEVOLENT INSTITUTIONS OF THE EVANGELICAL AND REFORMED CHURCH, ASSOCIATION OF EPISCOPAL HOSPITALS, Congress Hotel, Chicago, Feb. 28, March 1.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 30-May 1.

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NEWS...

Cutback of V.A. Hospitals Cost More Than \$10,000,000, V.A. Spokesman Asserts

WASHINGTON, D.C. — In support of congressional action looking toward restoration of the 16,000 bed cutback of the Veterans Administration hospital construction program, a V.A. spokesman last month said the cutback had already cost the government more than \$10,000,000. The money had been spent on plans, sites and preliminary work

by architects and contractors before the President ordered elimination of 24 new hospital projects and 13 additions, it was explained.

Some of the losses will be recovered, the V.A. spokesman said, if the cutback is restored before the present session of Congress is adjourned. A bill restoring the cutback was passed by the House last month and is awaiting action by the Senate, it was explained.

BUFFALO, N.Y. — Leaders of veter-

ans' organizations said here last month that the administration and the bureau of the budget were "trying to do away with hospitalization of veterans for non-service-connected disabilities." An American Legion official added that the legion had been "carelessly misquoted" on its stand in connection with the recommendations of the Hoover Commission on hospitalization costs.

Clyde A. Lewis of Plattsburgh, N.Y., speaking at a meeting of the Veterans of Foreign Wars here, said the 16,000 beds which President Truman sought to omit from the Veterans Administration construction program were "badly needed."

In another meeting, William J. Regan, a county official of the American Legion, said the legion was not opposed to the Hoover Commission report in its entirety or opposed to "economy and efficiency in government."

Teaching Unit Named for Dean Moffitt

SAN FRANCISCO.—The contemplated \$20,000,000 building program for the University of California Medical Center here will have as its first unit a teaching hospital to be known as the Moffitt Hospital, in honor of Dr. Herbert C. Moffitt, former dean of the university medical school, it was announced here last month. The hospital will be a 12 story structure and will be integrated with a medical sciences building featuring research facilities adjacent to and on the same floor with related clinical facilities in the hospital.

Dedicate \$2,000,000 Addition to Beth-El Hospital

BROOKLYN, N.Y. — Ceremonies dedicating the \$2,000,000 addition to Beth-El Hospital here were held last month with Oscar R. Ewing, Federal Security Administrator, as the principal speaker. Joseph I. Aaron, chairman of the hospital's building committee, laid the cornerstone for the new structure, which will add 120 beds to the present 240 bed hospital.

Mr. Ewing said he was opposed to any system under which all doctors would work for the government. "They have that kind of socialized medicine in Russia, and I don't want any part of it here," he declared. Mr. Ewing stated that he and President Truman would gladly relinquish their national health program—"if someone would come along with a better way to do the job."

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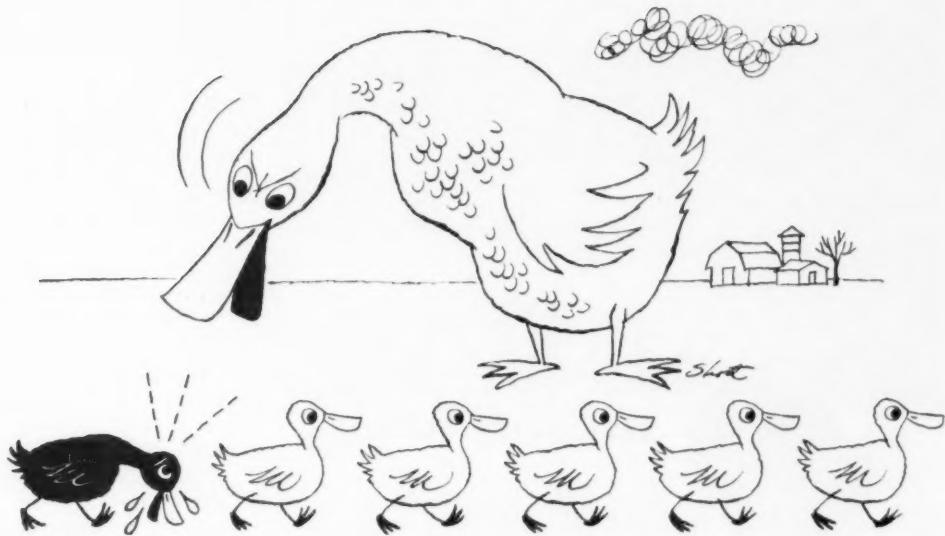
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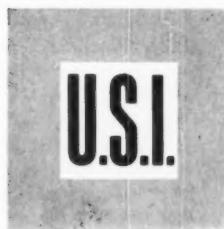


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Vol. 75, No. 1, July 1960

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ABOUT PEOPLE

(Continued From Page 88.)

Guidotti, a graduate of the Royal University of Naples, won the Legion of Merit decoration for his army medical services in World War II.

Dr. Henry Brill, assistant director of Pilgrim State Hospital at West Brentwood, L.I., since 1943, became director of Craig Colony for Epileptics, located at Soneya, N.Y., on June 1.

Harry M. Piper Jr. has been appointed

to the staff of St. Luke's Hospital, St. Louis, as assistant to the director. Mr. Piper, who assumed his duties at St. Luke's on June 15, had been publicity director of the St. Louis Chamber of Commerce since 1946.

Lt. Col. David C. Burke has been appointed the first chief of management in the history of the Army Medical Center, Walter Reed General Hospital,



D. C. Burke

Washington, D.C. Col. Burke has been adjutant of the center since February 1949. Prior to that, he was executive officer of the 71st Station Hospital in Korea. He was also commanding officer, 381st Station Hospital Detachment in Okinawa.

Hubert M. Johnson succeeded L. S. Messick as assistant director of James Walker Memorial Hospital, Wilmington, N.C., June 15. Mr. Johnson recently completed a course in hospital administration at Duke University School of Medicine.

Dr. J. Ralston Wells has been named manager of the Veterans Administration Hospital now under construction at Grand Island, Neb. Dr. Wells had been manager of the V.A. hospital at Dallas, Tex., since December 1947. He has been succeeded there by **Dr. Frederic R. Eastland**, chief of professional services at the V.A. hospital at Lake City, Fla.

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A black and white illustration of a female nurse in a white uniform and cap, bent over and washing a large metal bowl filled with surgical instruments like forceps and scalpels. The background shows more instruments on a table. A banner across the bottom of the illustration reads "PLEASANT ODOR - NON TOXIC - POWERFUL". Below the banner, the text "non-specific • economical • effective" is written in a stylized font.

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Margaret Rouillion

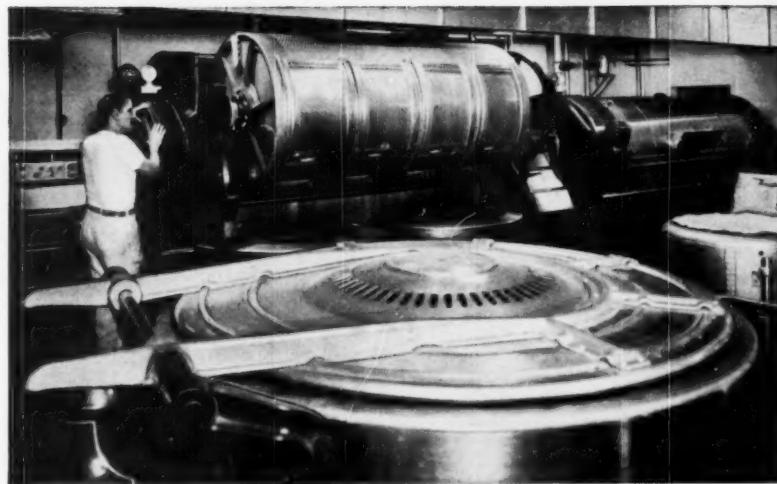
Department Heads

Margaret Rouillion assumed the position of director of social service at St. Luke's Hospital, New York City, on May 1, following the retirement of **Grace Cooke**, Miss Cooke had been in the social service department for 34 years and its director for 11 of those years.

Mrs. Edna Witham Dover, superintendent of nurses at Women's Hospital, New York City, for five and one-half years, and instructor at Hunter College for two years in clinical teaching, principles and methods of supervision and ward administration in hospitals, is now superintendent of nurses at Overlook Hospital, Summit, N.J. **Clothilde Munster**, who had been acting superintendent of nurses at Overlook, has been made assistant superintendent of nurses and educational director. Other appointments at Overlook are those of **Dr. George Manley Himadi** as full-time radiologist, and **Mrs. Frances Demas** as executive housekeeper.

Betty J. Snyder has been appointed executive dietitian of Baroness Erlanger Hospital, Chattanooga, Tenn. Miss Snyder joins the staff of the hospital direct from Kansas State College, where she acquired her master's degree in institutional management. Prior to her work at Kansas State College, she was with

SPEEDS PRODUCTION.
Pushbutton control governs unloading of work from this Cascade Automatic Unloading Washer into Notrux Extractor containers. Job takes less than a minute. Mechanized laundry department at Deaconess Hospital uses Monel® Notrux Extractor (foreground) saves up to 22 man-minutes a load. Photo courtesy of American Laundry Machinery Co. and Deaconess Hospital.



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Boosting Laundry Output and Saving \$218 a Week

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This 225-bed institution needed more laundered linens than its hard-pressed laundry department could turn out in a 54-hour work week.

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That did it! Today, thanks to modern high-speed production methods, all departments at Deaconess Hospital have plentiful supplies of sterile-clean linens. What's more, the laundry manager has been able to release 5 workers to other

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Cook County Hospital, Chicago, and superintendent of nurses at Randolph Victory Memorial Hospital, Waukegan, Ill.

Dr. Elliott S. Hurwitt has been appointed chief of the surgical division of Montefiore Hospital, New York City, on a full-time basis.

Annie Laurie Green has resigned as superintendent of nurses of Randolph Hospital, Asheboro, N.C., to become an esthetician on a full-time basis at the same hospital. **Marie Hutchins**, for the last 12 years superintendent of nurses at Piedmont Memorial Hospital, Greensboro, N.C., succeeded Miss Green as

Trustees

Charles D. Halsey, president of the United Hospital Fund, has been re-elected chairman of the board of trustees of New York Medical College.

Deaths

John E. Ransom, director of the division of hospital services in the Georgia State Health Department, died recently in Atlanta, Ga., as the result of injuries received in an automobile crash April 29.

He was 68 years old. In his long hospital career, Mr. Ransom was associated with several hospitals in the eastern United States. At one time he was executive director of the Greater New York Hospital Council. For 13 years he was assistant director of the Johns Hopkins Hospital, Baltimore.

Taft Predicts Defeat of Plan to Create Separate Health, Security Department

WASHINGTON, D.C. — This year's proposal by the administration to create a separate government department of health, education and security is substantially the same as the reorganization measure defeated by Congress last year. Senator Robert A. Taft of Ohio said during a debate on the current proposal here last month. The President's "Reorganization Plan No. 1" was defeated a year ago following a vigorous opposition by the American Medical Association.

"The same idea has been current for quite a while," Senator Taft stated. "The difficulty is that health, education and security are all different subjects. The only respect in which they are grouped together in the present Federal Security Administration is that they are all matters in which the federal interest is secondary and the matter of principal interest is aid to the states."

"The Hoover commission recommends setting up a department of education and security, with a health division in an entirely separate medical administration. The welfare people want to run health as a kind of welfare service. Doctors and others feel that medical care is a special subject which ought to be dealt with by people who are experts in the health field and not subject to welfare direction."

"It is true that this plan separates these three functions into separate departments under a secretary, but the secretary has an assistant secretary and an under secretary, all of whom are likely to be welfare people, and then it isn't perfectly clear that all health functions have to be assigned to the surgeon general of the Public Health Service."

Senator Taft predicted that the new plan would be defeated "apparently because Oscar Ewing would just turn the Federal Security Administration into a government department and in turn make Oscar Ewing a secretary in the cabinet. There is a good deal of resentment in Congress about that," he told his audience.



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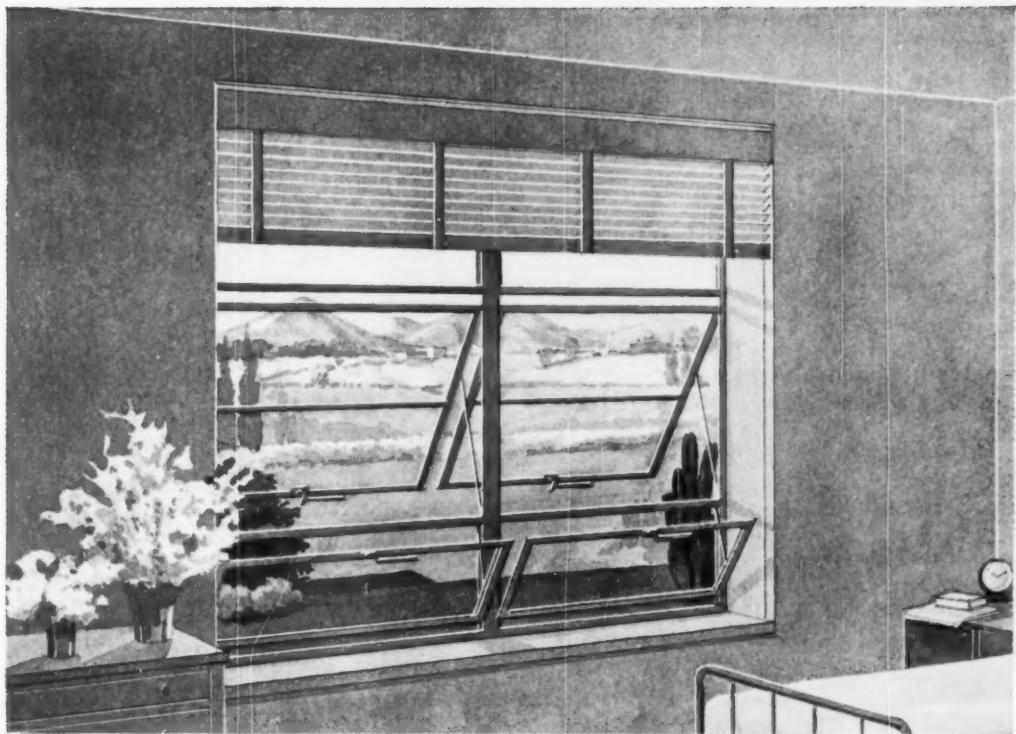
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LUPTON METAL WINDOWS

Research Building Started

ATLANTA, GA.—Construction of a medical research building in connection with Emory University Hospital here was scheduled to begin last month, according to an announcement by Dr. Goodrich C. White, president of the university. The building will cost an estimated \$1,500,000 and will feature special facilities for cancer research and for investigative projects by the medical school and hospital staff, the announcement said. Robert and Company Associates of Atlanta are the architects for the medical research hall.

THE BOOKSHELF

A STUDY OF STAFFING THE SMALL GENERAL HOSPITAL OF LESS THAN 100 BEDS. Prepared by Margaret K. Schafer, Division of Medical and Hospital Resources, Public Health Service, Federal Security Agency. April 1950. Pp. viii-101.

This report of a study of the staffing problems of small general hospitals com-

prises 100 mimeographed pages consisting mainly of 79 tables of statistics.

Although 41 hospitals of less than 100 beds were visited in various sections of the United States from February to November 1948, the findings of 22 hospitals are reported. Evidently the more nearly ideal situations were used and the basis for selection is given.

Even with the "ideal" situations only 10 hospitals had pathologists and radiologists' services primarily on consultation basis; none of the hospitals employed a full-time pharmacist; only 10 hospitals employed anesthetists; eight hospitals were without dietitians; eight were without record librarians (as such), and one had no x-ray or laboratory service. If this is the situation in 22 selected hospitals which presumably were providing acceptable services in 1948, what will be the situation in all the new small hospitals now being constructed with Hill-Burton funds?

Numerous charts are devoted to the nursing situation. The most interesting are those related to the ratio of professional nurses to nonprofessional nursing personnel. In the 22 hospitals the variation is great: in one hospital, 94.1 per cent of total nursing personnel are professional nurses and at the other extreme 31.4 per cent of the nursing personnel are professional nurses.

The study found there was no relationship evidenced between the ratio of personnel needed and the size of the hospital or the number of patients. Charts of total personnel, of personnel by departments, personnel in ratio to beds, to beds and bassinets, to patients, excluding and including newborn, are given. Frequent evidence was given that the problems of staffing small general hospitals vary greatly.

For those who like charts and figures, this is a fascinating study and one which makes a person reach for a pencil to compare the figures quoted with those of one's own institution. Perhaps by now this study may be out of date for changes in personnel policies and perhaps changes in concepts may have rendered some findings no longer applicable. It does call attention to the needs of the small hospital and to the wide variations that exist even in selected hospitals. A good summary of findings is given.—EVA H. ERICKSON.

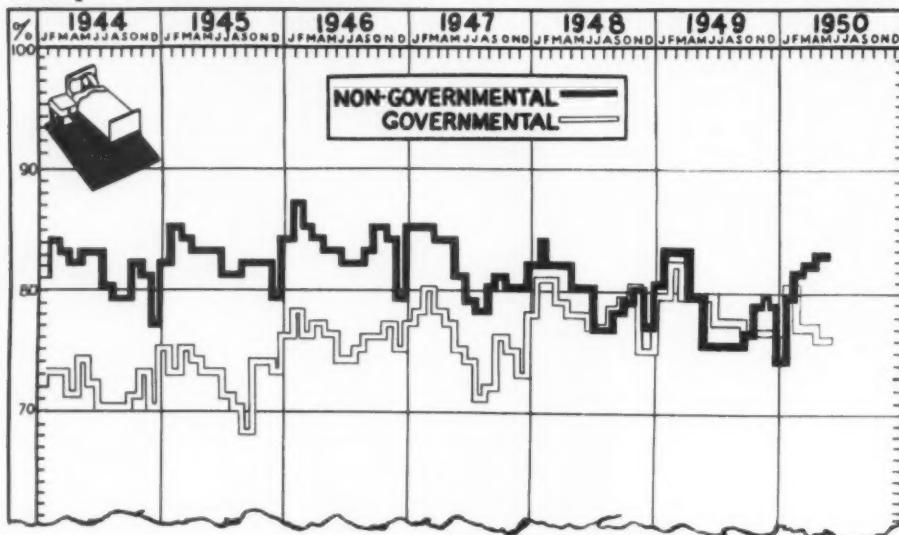


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Hospital Construction 23 Per Cent Over Last Year



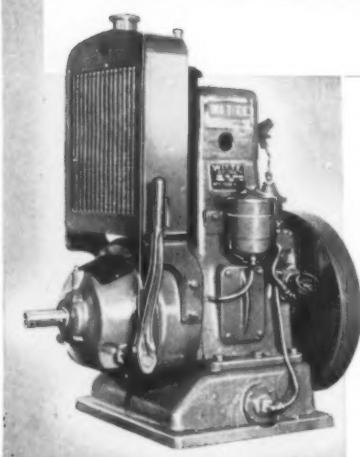
At 81.4 per cent of capacity, the occupancy of nongovernmental hospitals reporting to the Occupancy Chart for the month of May was slightly higher than in April. Governmental hospitals reported about the same occupancy as in the

month of April, which was 81.3 per cent.

Hospital construction reported in the last month totaled \$87,287,000, making the total for the year to date \$339,587,000. This is an increase of 23 per cent over the total for the same period in

1949. Of 48 projects reported during the latest period, 23 were new hospitals. Total cost of these was \$40,817,000. Of the remaining projects, 21 were additions and four were nurses' homes totaling \$1,507,000.

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Immense \$18,000,000 Veterans Hospital selects AMERICAN-Standard

The new 1005-bed, 2328-room Veterans Administration Hospital in Buffalo, N. Y., is truly a modern hospital. The color scheme, selected with an eye to both visual effect and therapeutic value, embodies twenty-eight shades and tones of lively colors. The hospital was designed to admit maximum light and air. The bold cruciform pattern marks a complete break with past traditions of hospital design.

But in its selection of plumbing fixtures and heating equipment the Buffalo hospital did what hospitals all over the country are doing—it selected American-Standard products . . . including all the radiators and convectors, and such specialized plumbing fixtures as autopsy tables, sitz baths, scrub-up sinks, prolonged treatment baths.

Dependable, efficient American-Standard Heating Equipment and Plumbing Fixtures meet the most rigid hospital requirements. And there's a complete line to choose from. So, when you equip your hospital, ask your Architect and Engineer or your Heating and Plumbing Contractor about American-Standard Heating Equipment and Plumbing Fixtures. They'll gladly help you select the products best suited to your particular needs. **American Radiator & Standard Sanitary Corporation**, P. O. Box 1226, Pittsburgh 30, Pa.

Architects and Engineers: Green, James & Meadows and Eggers & Higgins

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Plumbing Contractor: Carl C. Grimm

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These sturdy cast iron **PROLONGED TREATMENT BATHS**, finished inside with acid-resisting enamel, are of ample size and depth and have strong cast iron legs. **SITZ BATHES**, in background, are made of genuine vitreous china to assure lasting good looks and a surface that is smooth, hard, easy-to-clean. Designed for utmost comfort of patient and convenience of the nurse.

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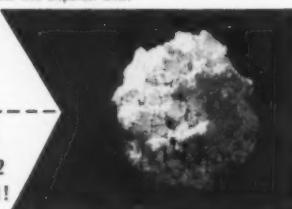
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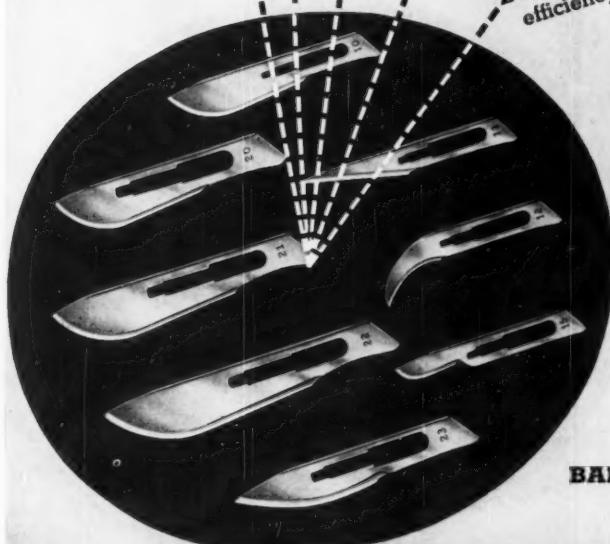
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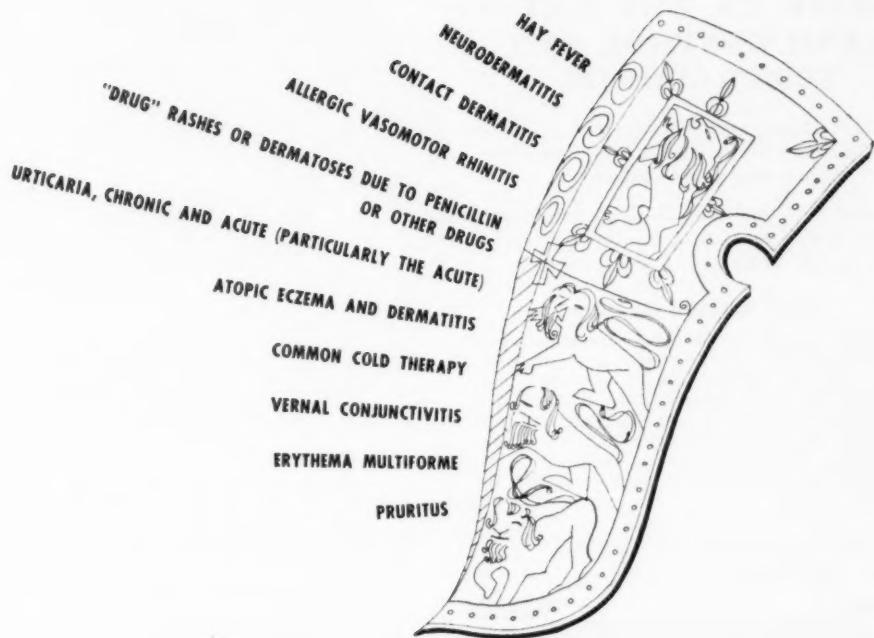
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References

Combes, F. C., Zuckerman, R. and Canizares, O.: Diatrin Hydrochloride; A New Antihistaminic Agent for the Treatment of Pruritus and Allergic Dermatoses, *Ann. of Allergy*, 7:676, 1949.

1.

Kugelman, I. N.: Antihistaminic Therapy of Allergic Disorders in Infants and Children, *N.Y. State J. M.*, 49:2313, 1949.

2.

Combes, F. C., Zuckerman, R. and Canizares, O.: Diatrin Hydrochloride; Clinical and Toxicologic Studies of a New Antihistaminic Agent, *J. Invest. Dermatol.*, 13:139, 1949.

3.

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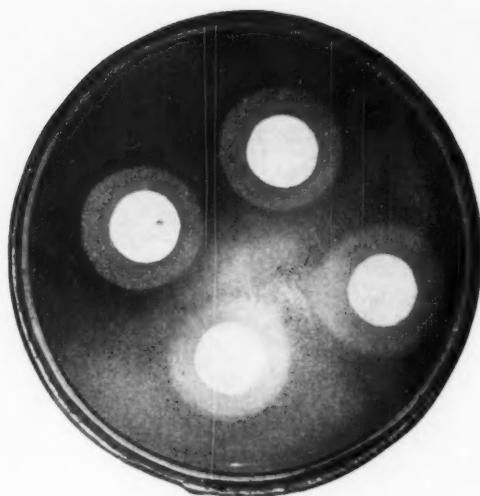
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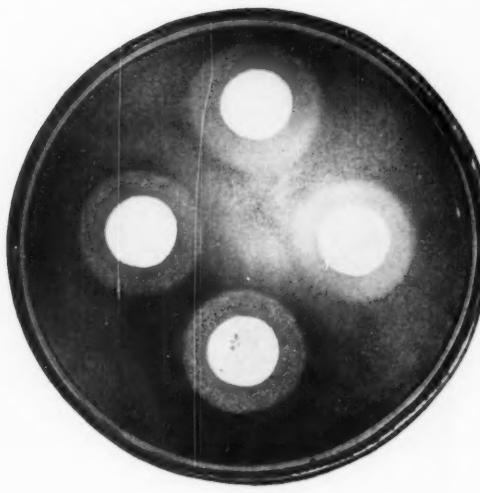
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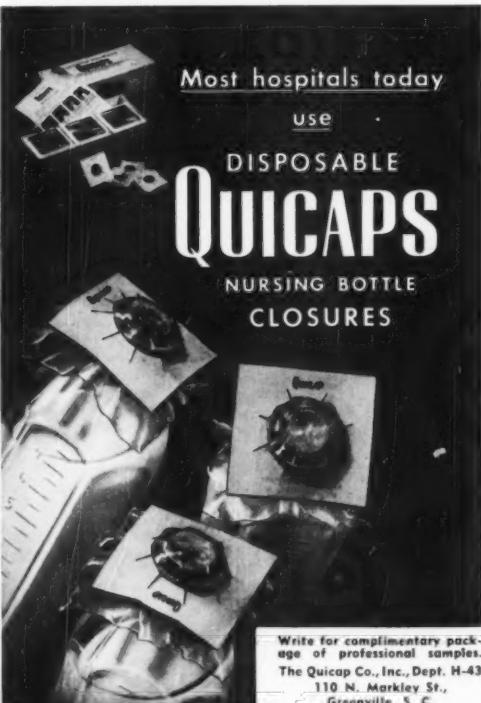
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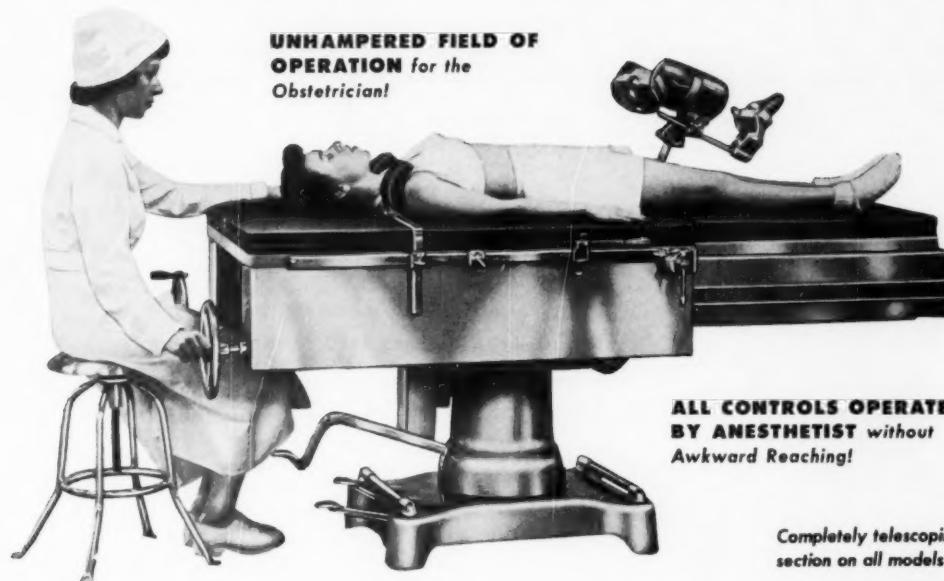
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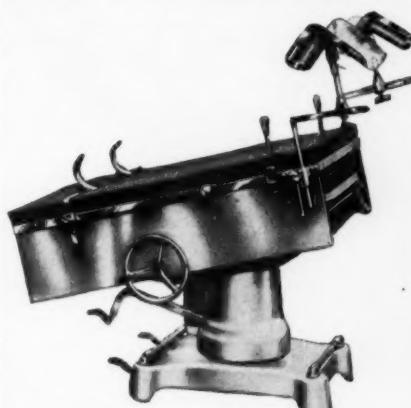
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(Continued on page 184)

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(Continued on page 186)

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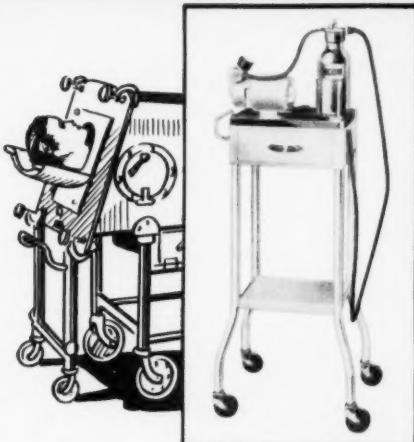
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INSTRUCTORS—Science; excellent opportunity; clinical; immediate vacancy; for approved school of nursing; 400-bed general hospital, vacation and sick leave policy. For details, apply Personnel Director, The Christ Hospital, Cincinnati, Ohio.

INSTRUCTORS—Nursing Arts and Science; must be fully qualified; class of 32 students September 1st; fully accredited school; good personnel policies; salaries open. Apply to Director of Nursing, Roger Williams General Hospital, Providence, Rhode Island.

LIBRARIAN—Medical Records; position for person with experience, department of medical records; need not be registered but must be able to install standard nomenclature; stenography required; good salary, full maintenance; 63-bed modern hospital, Pennsylvania; good working conditions. MO 74, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LIBRARIAN—Medical record; for county hospital; must be active member of the American Association of Medical Record Librarians; salary \$210 per month with periodic increases to \$282. Address County Civil Service Office, 242 Third Street, San Bernardino, California.

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MISCELLANEOUS—Operating room supervisor and night obstetrical nurse; for 55-bed general hospital; salary open; full maintenance in nurses' residence; vacation and sick leave; college city, population 10,000. Apply, Superintendent, Jane Case Hospital, Delware, Ohio.

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(Continued on page 188)

MISCELLANEOUS—Supervisors and Staff Nurses needed for Maryland State Tuberculosis Hospital; merit system status offering generous vacation and sick leave, retirement benefits, and automatic salary increases; salaries are now under study; new building program will offer exceptional opportunities for advancement in administrative and educational programs. Apply, Director of Public Health Nursing, Maryland State Department of Health, 2411 North Charles Street, Baltimore 18, Maryland.

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NURSE—Psychiatric; able to teach some nursing classes and supervise training courses in a state hospital; \$325 a month; give age, experience. Address Superintendent, State Hospital, Madison, Indiana.

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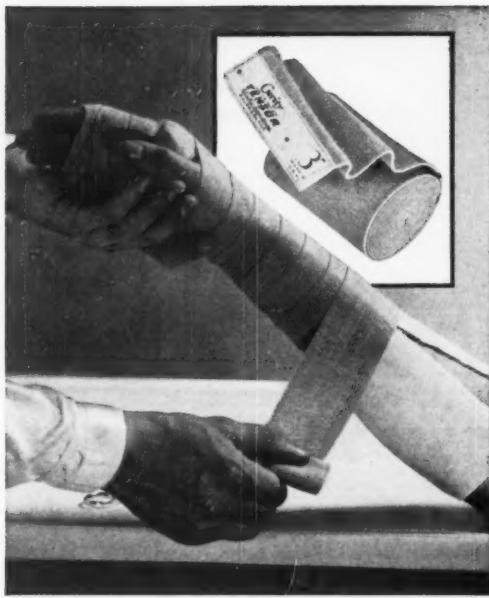
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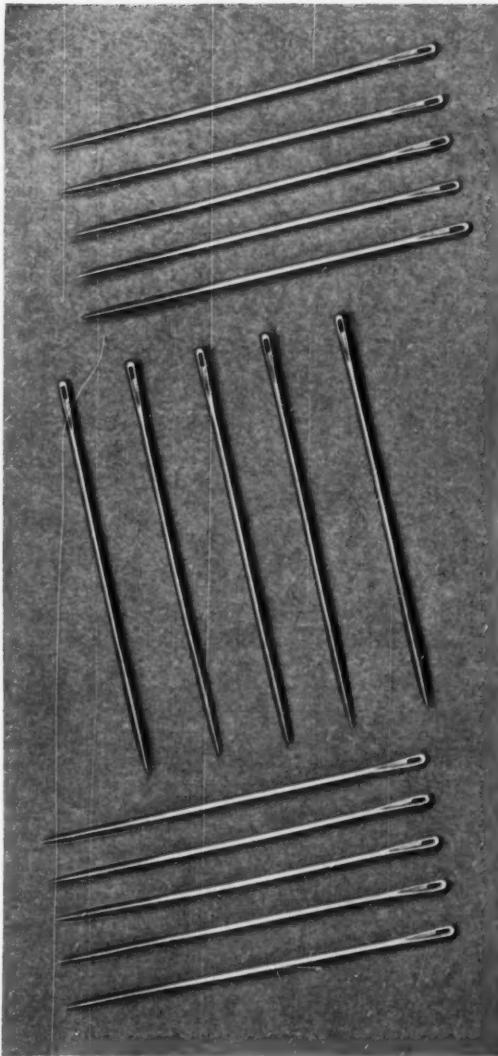
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NURSES—Full or part-time assignments; opportunities for progressive experience in general hospital near university; special surgical program; convenient living quarters and food service in residence hall. Address: Director of Nursing, Mount Sinai Hospital, Cleveland, Ohio.

NURSES—General staff; for 740-bed general hospital; 44-hour week; rotating shifts; salary, junior staff, \$2400-\$2580 per year, in 2 years; senior staff, \$2460-\$2640 per year, in 2 years; \$20 per month additional for evening and night duty; two weeks' vacation and two weeks' sick leave allowable on accrual plus gratuitous basis. Write, Superintendent of Nurses, Barnes Hospital, St. Louis 10, Missouri.

NURSES—Registered nurses and registered psychiatric nurses; men and women; for state hospital assignments, for general duty, hospital work, tuberculosis and psychiatry; also registered psychiatric nurses with college degree as instructors of affiliating schools of psychiatric nursing; good salaries; opportunity for advancement; excellent retirement and insurance plan. Write, Division of Personnel Service, Department of Public Welfare, State Armory, Springfield, Illinois.

NURSES—Staff; for Hahnemann Medical College and Hospital of Philadelphia, Pennsylvania; many fine positions now available in teaching institution with opportunities for advancement and time allowed for advanced study; centrally located in metropolitan area; liberal and democratic policies enforced, some of which for general staff are a 44-hour week; \$170 per month; 4 full or 12 half holidays during year; generous sick time granted; laundering of uniforms and one meal free; comfortable living accommodations provided in nurses' residence if desired; rotating shifts, not longer than 4 weeks' for evening or night duty unless permanent assignment requested; liberal increases of salary granted for rotation. For further information, write to Associate Director of Nurses, Hahnemann Medical College and Hospital, 230 North Broad Street, Philadelphia, Pennsylvania.

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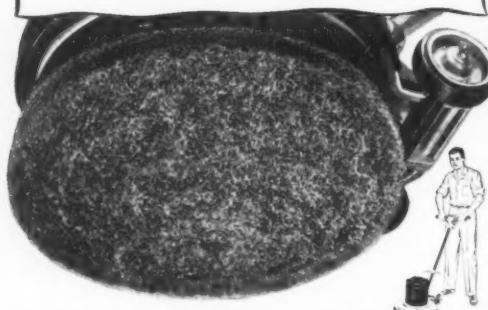
NURSES—Registered; for work in Los Angeles County Hospitals; \$221 per month, 40-hour week; civil service benefits. Apply Los Angeles County Civil Service Commission, 501 N. Main Street, Los Angeles 12, California.

NURSES—General duty; preferably with experience; one for permanent night duty in newborn nursery, 45 bassinets; also one for medical and surgical ward; salary, \$215 plus meals and laundry; \$10 increase after 60 days; living accommodations if desired; attractive new nurses' residence to be opened in November; 210-bed general hospital in residential suburb of Chicago. Apply to, Director of Nursing, MacNeal Memorial Hospital, 3249 South Oak Park Avenue, Berwyn, Illinois.

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(Continued on page 190)

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SOLID DISC STEEL WOOL
FLOOR PADS

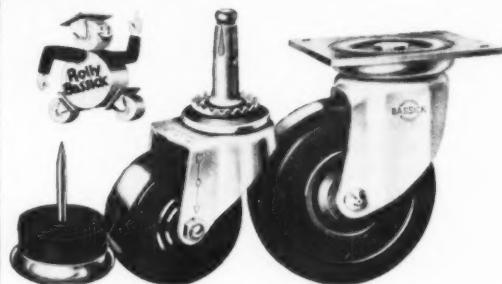
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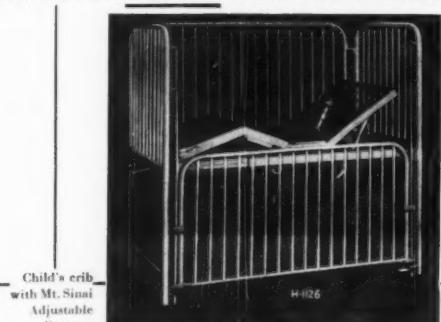
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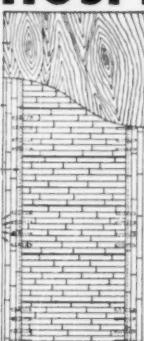
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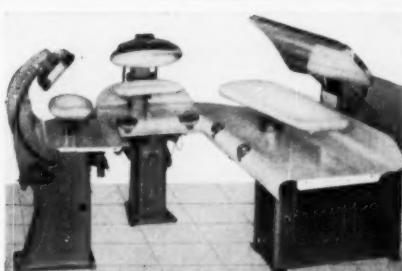
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SUPERVISOR—Operating room; for private and semi-private operating rooms; experience in large hospital is required; immediate opening good salary and working conditions. Apply to, Superintendent of Nurses, The Mount Sinai Hospital, 11 East 100th Street, New York 29, New York.

SUPERVISOR—Operating room; experienced, post graduate work; B.S. Degree; pleasing personality; interested in student education; capable of efficient management of heavy operating room schedule; 309-bed hospital; living accommodations if desired. Write Director of Nurses, The Jewish Hospital, Cincinnati 29, Ohio.

SUPERVISORS—Operating room, obstetrics, medical-surgical, evening and night; staff nurses for all services; modern new hospital in small southern city; salaries dependent on qualifications. Contact Director of Nursing Service, Jackson-Madison County General Hospital, Jackson, Tennessee.

SUPERVISORS—For medical and surgical nursing, wards; medical and surgical nursing, private; large general hospital; administrative duties only; degree and experience preferred; overall cash salary depends upon qualifications. Apply, Superintendent of Nurses, Cooper Hospital, Camden 3, New Jersey.

SUPERVISORS—Obstetric and Operating room; for 35-bed community hospital in southern Wisconsin; special preparation or experience necessary; salary open depending upon qualifications; maintenance included. Apply, MO 90, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Obstetrical, assistant; salary open; provision can be made for living in. Write, Director of Nursing, Middlesex General Hospital, New Brunswick, New Jersey.

TECHNICIAN—Laboratory; registered; new 50-bed hospital in thriving village, Catskill Mountains; permanent or from May through October; salary open. Margaretville Hospital, Margaretville, New York.

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(Continued on page 192)



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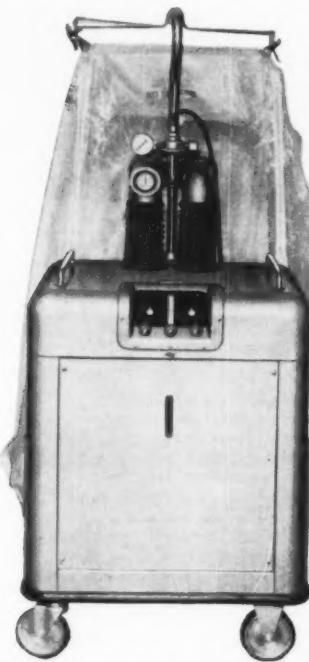
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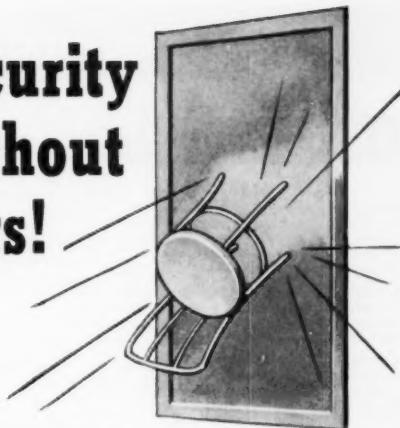
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INTERSTATE—Continued

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(Continued on page 194)

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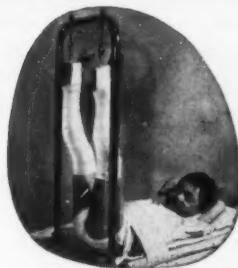
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Absolutely safe for heaviest patient. Step adjustable IN and OUT instantly to either side of bed—right or left. Eliminates need for footstools. No floor maintenance obstruction. Provides handy out-of-sight under-bed shelf for bed pan, slippers, etc.

Available through Hospital Supply Dealers. Write us for folder.

THE FOSTORIA PRESSED STEEL CORP.
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Clamps to bed frame — Easily attached and removed.

Step slides in U channel steel frame — Foot pressure locks step securely.

Step Guards control proper extension of step.

Steps have non-skid finish to prevent foot slippage.

MODERN HOSPITAL EQUIPMENT Inspired These New Sanettes

Now you can have smartly designed waste receptacles that look just right with the most modern hospital furnishings and equipment . . . as generous in capacity as you want them and expertly sized as to height and minimum floor space. They are available in snow white, special colors and stainless steel finishes for private rooms, wards, clinics, solariums, kitchens, laboratories, and nurseries.

Each of the three sizes, (Model M-12, 3 gal., Model M-16, 4 gal. and Model M-20, 5 gal.) is equipped with a leakproof, acid-and-rust-resisting, hot dipped, galvanized inner pail, round in shape. Covers are rubber edged, of special overhanging shape, designed to seal in odors.

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MASTER METAL PRODUCTS INC.

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MODEL M-20-AS
Height 26"; 11" Square



MODEL M-16
Height 23"; 11" Square

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SHAY MEDICAL AGENCY

Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

DIRECTOR OF NURSES—East; 150-bed hospital; Degree in Nursing Education required; director is also principal of school of nursing; this is a fine opportunity for someone with a completely progressive viewpoint towards nursing education; unlimited opportunity; \$5,000-\$6,000.

DIRECTOR OF NURSES—Middle west; new, modern 60-bed hospital located in town of 10,000 within easy commuting distance of larger cities; no training school; excellent opportunity; \$5,000 plus full maintenance.

NURSE ANESTHETIST—East; general hospital of 150 beds located in city of 30,000; department well staffed; all modern equipment; \$4,800 plus full maintenance to start.

ASSISTANT DIRECTOR OF NURSES—Northwest; 200-bed hospital, affiliated with two universities; located in city of 50,000, beautifully situated in scenic mountainous country; many recreational facilities; \$3,600-\$4,200, depending upon qualifications.

SHAY—Continued

CLINICAL INSTRUCTOR—Medical and surgical division; 150-bed hospital located in beautiful New England city; many cultural and recreational facilities available; hospital has very progressive personnel policies; there are 66 student nurses in the three year basic program; excellent affiliations in pediatrics, communicable disease and psychiatric nursing; \$3,000-\$3,600 plus full maintenance.

WOODWARD MEDICAL PERSONNEL BUREAU (Formerly Axone's)

Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

ADMINISTRATORS—(a) Medical, assistant; general hospital comprising 300-bed addition; experienced man preferred; will consider recent medical graduate interested in remaining in administration; New York licensure required. (b) Lay; well equipped, well staffed 150-bed general hospital, desirable city; 75,000; north central. (c) Medical, 400-bed charity, private and psychiatric units; requires doctor with demonstrable ability and scientific interest; southern city; 150,000; substantial salary. (d) Lay; 150-bed general hospital used primarily for railway employee patients; must

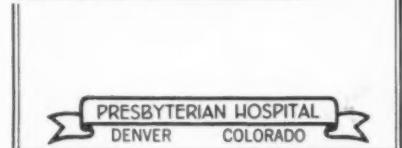
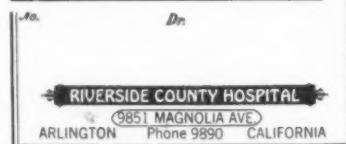
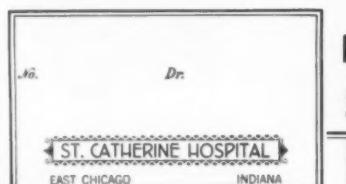
WOODWARD—Continued

be capable; southwest; \$7,000. (e) Lay; Spanish speaking, preferably Catholic for 250-bed psychiatric hospital situated in tropical United States dependency; mild climate; known to us and recommended. (f) Lay; non-profit institution contemplating new 50-bed hospital; preferably individual experienced in dealing with Texans. (g) Lay; 140-bed eastern voluntary general; excellent school of nursing; requires individual with good experience; substantial salary. (h) Lay; 150-bed general voluntary hospital; western college town, 25,000. (i) Lay; 100-bed general voluntary hospital being completed soon; very fine residential town 16,000; east central. (j) Lay; well equipped general hospital of 125 beds well located in Michigan city 75,000. (k) Lay; general voluntary hospital of smaller size situated in desirable Ohio town, 12,000. (l) Medical, assistant; teaching hospital located interesting large southern city; Degree in Hospital Administration essential; good salary. (m) Lay; male or female; new 40-bed hospital being built by excellent, old established 6-man group; no training school; attractive midwest town; about \$5,000 initially. (n) Lay; male or female; combined with purchases; personnel 70-bed tuberculosis hospital, church related; residential community suburban to large eastern medical center metropolitan.

ADMINISTRATIVE STAFF APPOINTMENTS—Trained business manager; 125-bed general hospital situated foot hills of Great Smoky Mountains; must be familiar with A.H.A. accounting systems.

(Continued on page 196)

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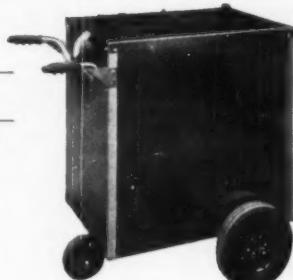
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- Hypodermic Needles
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Bishop's efficiently-designed, "sharper-than-ever," stainless steel needles with precision-made chrome plated hubs, when teamed with the "Blue Label" precision-made Syringe is your assurance that you have the finest in hypodermic appliances right at your fingertips.

Quality and service considered, they are your real "economy package."

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Modern,
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Way...*



WITH A *Finnell* SCRUBBER - VAC

This combination machine applies the cleanser, scrubs, rinses if required, and picks up—all in one operation. With one or two operators, a *Finnell* Scrubber-Vac can do a cleaning job better in half the time it takes a crew of six to eight using separate equipment for the several operations.

The model shown above, for heavy duty requirements, cleans up to 8,750 sq. ft. per hour. Has new type of water valve that assures uniform flow of water . . . powerful vacuum for efficient pickup . . . a *Finnell*-developed trouble-free clutch, affording effortless operation . . . improved waterproof wiring and minimum electrical connections simplifying the cleaning of the machine. Vacuum performs quietly.

Finnell makes a full line of combination machines, all self-propelled, including a model for small-area buildings with 2,000 to 15,000 sq. ft. of floor space. This machine reduces cleaning time approximately two-thirds! Handles both wet and dry work.

It's good to know that when you choose *Finnell* Equipment, a *Finnell* man is readily available to help train your maintenance operators in its proper use. For consultation, demonstration, or literature, phone or write nearest *Finnell* Branch or *Finnell* System, Inc., 1407 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.



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THE MEDICAL BUREAU

Burnice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATORS—(a) Medical director; teaching hospital; medium bed capacity; position carries faculty appointment, school public health; university medical center; midwest. (b) Medical; for important position with one of the national organizations; capable public speaker required. (c) Lay; general hospital, 300 beds; university town, 100,000, southwest. (d) Lay; qualified handle administrative affairs, large institution; New England. (e) Assistant superintendent; young physician interested in hospital administration required; 600-bed general hospital; east. (f) General hospital currently under construction, completion expected January 1st; capacity around 150 beds; preferably one available by October 1st; college town of 40,000, Pacific Northwest. (g) City-operated hospital, 100 beds; town of 50,000, middle west. (h) General hospital recently completed, now ready for operation; 125 beds, town of 20,000, northern state. (i) Night superintendent; university affiliated hospital, 300 beds; expansion program; middle west. (j) Assistant; voluntary hospital, 500 beds; preferably man in forties; university graduate with considerable experience; east. (k) Assistant; hospital operated by American company in Africa. (l) Two administrative assistants; 600-bed hospital;

MEDICAL BUREAU—Continued

medical school affiliations; east. (m) Assistant; general hospital; Marshall Islands. (n) Assistant; accounting background required; duties include complete charge of business office; 300-bed general hospital; east. MH7-1.

ADMINISTRATORS—Nurses. (a) General hospital, 250 beds; extensive experience required; should be member or fellow, American College of Hospital Administrators. (b) New hospital, 75 beds, nearing completion; college town, short distance from several large cities, midwest. (c) Assistant; general hospital, 125 beds; should be qualified to succeed director upon retirement. MH7-2.

EXECUTIVE PERSONNEL—(a) Personnel director; teaching hospital, 700 beds; man required. (b) Purchasing agent; fairly large hospital, California. (c) Chief admitting officer; general hospital, 600 beds; young administrator preferred; east. (d) Director of personnel and public relations; 400-bed hospital; university center. (e) Business manager, 150-bed hospital; newly created position; New England. MH7-3.

ANESTHETISTS—(a) To join staff of well known clinic founded by famous surgeon; university medical center; \$400 monthly including meals, laundering of uniforms. (b) Two; small general hospitals located in resort area of Pacific Northwest; beautiful new hospital; capacity 200; \$4200. (c) Modern well equipped hospital operated under American auspices in Venezuela; knowledge of Spanish desirable; immediately. MH7-4.

MEDICAL BUREAU—Continued

DIRECTORS OF NURSES—(a) Large teaching hospital; university town of 100,000, east; minimum \$6000. (b) General hospital, 300 beds; 110 students; university medical center, south; substantial salary, complete maintenance, including apartment. (c) Voluntary hospital, 300 beds; staff of full-time specialists, American Board men; nursing department well staffed; residential town located few miles from university and college center; east. (d) Director, school of nursing, now being established by university; outstanding opportunity; Master's Degree desirable. (e) Teaching hospital maintaining college of nursing for eighty students; several years' experience required; Master's Degree desirable; west. (f) General; 200-bed hospitals; medical school affiliations; university center; midwest. (g) To take charge of nursing services for two small general hospitals, combined bed capacity 150; town of 20,000, Pacific Northwest; \$6000. (h) Director, nursing service; new hospital, general, 80 beds; residential town on Lake Michigan, short distance from Chicago. (i) Assistant director, school of nursing having collegiate affiliations; excellent opportunity for advancement; beautiful location, California. MH7-5.

EXECUTIVE DIRECTOR—Federation of four nursing organizations founded to promote better nursing service and welfare of nurses; 10,000 members; degree, administrative experience, familiarity with several fields of nursing including public health and nursing education required. MH7-7.

(Continued on page 198)



for hospital dishwashing

SALVAJOR Gives "7" SCRAPPING BENEFITS

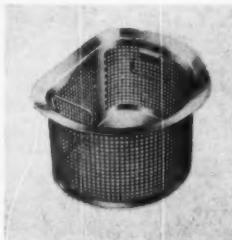


SCRAPPING & PRE-WASHING In One Action

There's no rough scrapping of dishes before pre-washing with a Salvajor. It does both simultaneously by just passing tableware through the Salvajor stream of tepid water. No sprays to handle. No waste of hot or cold water because it's mostly recirculated.

LESS GARBAGE HANDLING

As Salvajor scraps and pre-washes it also collects the debris and automatically drains away the liquid, thus reducing food waste content about 50%. Food waste is left relatively dry and odorless for disposal.



NO TABLEWARE LOSS IN GARBAGE

Silverware and small china cannot be scrapped carelessly into the garbage when using the Salvajor. A patented trap actually separates the silverware from scraps and food waste during the scrapping and pre-washing operation.



Four Additional SALVAJOR Benefits

- ✓ Better Dishwashing Operation With Less Maintenance. A Salvajor Scrapping & Pre-Wash reduces shut-downs for scrap screen cleaning.
- ✓ Less Detergent & Hot Water Needed for Dishwashing. A Salvajor Scrapping & Pre-Wash reduces number of dishwashing water changes.
- ✓ Space By Pre-washing. A Salvajor eliminates waste motion over space pre-wash methods.
- ✓ Space Savings. A Salvajor Jr. Model occupies only 15 inches of table space. Fits any scrap table.



You Can Get a Proved

PATENTED

SALVAJOR

as low as

\$295*

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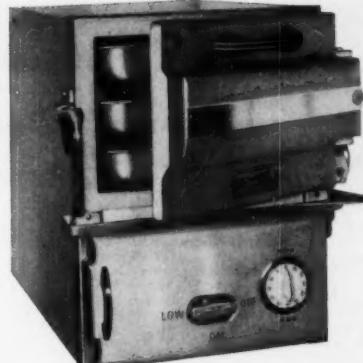
Also "WasteXit" Food Waste Disposers To Suit All Requirements

See Your Dealer or Write Manufacturer

THE SALVAJOR COMPANY

118 Southwest Blvd. Dept. MH

Kansas City, Mo.



Steameraff Cub counter model. Takes 3 full size pans or 6 half-pans. Steam heated \$235.00, gas \$265.00*, electric \$305.00*. Can be furnished with base. Indicating timer shown at slight extra cost.

What Steamcraft Users Tell Us:

"The most important equipment in our kitchen."

"It has improved everything we have cooked."

"We are 100% sold on your steamers."

"It's worth its weight in gold."

"Foods are much more attractive and taste better."

"This Steamcraft is the finest piece of equipment for a kitchen not having much room."

"Best tool in the kitchen."

"It saves lifting heavy pots and kettles."

"We have the best vegetables around—so we are told."

"We would be lost without it."

"No kitchen should be without this steamer."

"The greatest emergency equipment in any kitchen."

Yes, food service operators everywhere swear by their Steamcraft steamers. In our files are many, many letters of strong endorsement. If you have not put a Steamcraft to work in your establishment—let us tell you more HARD FACTS about this indispensable cooker.

Steamcrafts are made in several sizes and models to suit your needs. Automatic clock control or indicating timer optional. For larger kitchens we make the heavy duty Steamcraft steamers. Any of these steamers can be supplied for direct steam connection or for operation on gas or electricity. Write your supply house or us for details.

*Subject to Federal Excise Tax.



Steameraff two-compartment model. Takes 6 full size pans or 12 half-pans. Steam heated \$285.00, gas \$345.00*, electric \$425.00*. Base and indicating timer shown are additional.

STEAMCRAFT DIVISION

THE CLEVELAND RANGE COMPANY

"The Steamer People"

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**Steamcraft
COOKER**

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POSITIONS OPEN

MEDICAL BUREAU—Continued

FACULTY APPOINTMENTS—(a) Educational director; central school, students from three hospitals; university city, midwest. (b) Nursing arts, public health and clinical instructors; basic program being established by university; four-calender year program combining general and professional education; east. (c) Instructor in nursing education; university appointment; south. (d) Educational director and nursing arts instructor; new hospital, 250 beds; small school; university town, 50,000, southwest. (e) Instructor in charge of education program including instructor in nursing arts, well equipped hospital operated under American auspices, Asia. (f) Educational Director; collegiate school, residential town, 70,000, near Chicago; \$4200, maintenance. MH7-6.

LIBRARIAN—To take charge of library, 600-bed hospital; large city, south. MH7-8.

MALE NURSES—(a) Industrial hospital; Chicago area. (b) Psychiatric hospital; university town, Midwest. MH7-9.

SOCIAL DIRECTOR AND COUNSELLOR—Voluntary hospital, 300 beds; college town, New England. MH7-10.

PUBLIC HEALTH NURSES—Several, to serve as industrial health consultants with large insurance company, New York, Boston, Chicago. MH7-11.

MEDICAL BUREAU—Continued

MEDICAL RECORD LIBRARIANS—(a) Chief, 300-bed hospital; eastern metropolis. (b) Chief; hospital and clinic; staff of 20 specialists; winter resort town, southwest. (c) General hospital; fairly large size; United States dependent; mild tropical climate. (d) Chief; voluntary hospital, 500 beds, New England. (e) Small general hospital, college town; Pacific Coast; minimum \$300. MH7-12.

PHARMACISTS—(a) Chief; new department, general hospital; minimum \$4000, California. (b) Chief; general hospital, 200 beds; Wisconsin; minimum \$4200. (c) New hospital; completion expected November; college town, south. MH7-13.

SCHOOL AND STUDENT HEALTH NURSES—(a) To serve as superintendent of nurses, student health department, eastern university. (b) Chief nurse and, also, staff nurses; public schools, town 80,000, midwest. (c) Student health nurse; liberal arts college; middle west. (d) Student health department, large hospital; university city, Pacific Coast. MH7-14.

SOCIAL WORKERS—(a) Psychiatric; new guidance center, coastal city, south. (b) Medical case worker; large general hospital; residential town near New York City. (c) Medical; to direct department, large teaching hospital. MH7-15.

SURGICAL NURSE—To assist American Hospital ophthalmologist, chief, department, eye surgery group clinic. MH7-16.

MEDICAL BUREAU—Continued

SUPERVISORS—(a) Operating room; new hospital, 400 beds; affiliated with university medical school; operating room staff of thirty. (b) Orthopedic; to standardize and improve nursing care on orthopedic wards, university hospital, university town, 40,000. (c) Psychiatric; newly created department in new wing of well established hospital; department averages 36 patients, principally private; college town, 100,000. (d) Pediatric, obstetric and surgical floors; general hospital, 450 beds; new, air-conditioned residence recently completed; university city of 300,000, southwest. (e) Operating room; modern hospital operated under American auspices, Asia. MH7-17.

STAFF NURSES—Several; relatively new hospitals operated in connection with 25-man group clinic; \$70 weekly; west. MH7-18.

TECHNICIANS—(a) Laboratory supervisor qualified to assume responsibility for departments of hematology, urinalysis, BMR-EKG and, also, biochemist, M.S. Degree; large hospital, university medical center; midwest; \$3600-\$4200. (b) Chief x-ray technician; 450-bed general hospital; eastern metropolis; around \$4000. (c) X-ray and laboratory technician; clinic appointment; Alaska. (d) Chief laboratory technician; preferably male, experienced all laboratory procedures; training in parasitology, chemistry desirable; x-ray knowledge advantageous; new hospital; South America; \$4800. MH7-19.

(Continued on page 200)



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The Nestle Company, Inc., 155 East 44th St., New York 17, N. Y.

*as a hot drink . . .
as a basis for cooking*

BOUILLON STIMULATES CONVALESCENT APPETITES

Rich in beefy flavor, Maggi's Granulated Bouillon Cubes made into a delicious "broth" augment the appetite and promote digestion in debilitated states following illness and in various asthenic conditions.

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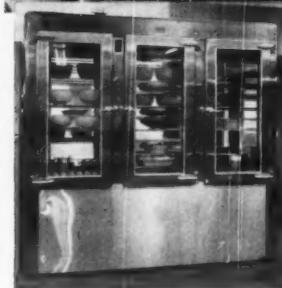
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CHARLIE'S
CAFE
EXCEPTIONALE

IN MINNEAPOLIS



Shown above are HERRICK Model RSS66 Reach-In and a custom built HERRICK double-front pass-through type Reach-In. This kitchen also contains five other HERRICK Refrigerators.

At left is a close-up of a custom built all stainless steel HERRICK Reach-In used exclusively for chilling "Charlie's" famous hors d'oeuvres.

"Charlie's" national fame for fine food has been achieved with the help of seven HERRICK Refrigerators. You, too, can count on HERRICK to enhance your reputation by keeping your foods and beverages at their delicious best. HERRICK's complete food conditioning assures peak freshness and flavor always. Compare HERRICK Stainless Steel refrigerators with any other make, and you'll see why HERRICK is the choice of so many discriminating users who demand the finest. Write for name of nearest supplier.

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The Aristocrat of Refrigerators



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Prepares Hundreds of Standard Dishes Better, Faster, Safer...
at LOWER COST

Any institutional, hotel, or restaurant kitchen can save enough time and eliminate enough waste with this machine to write off its cost many times. At the same time, menus can be more varied; food will be more attractive in appearance and richer in flavor.

In just a few seconds this powerful cutter will blend and cut a twenty pound batch of food ingredients to any degree of fineness. There is no mashing or burning, no squeezing or drying. All natural juices are retained in raw or cooked vegetables, meat, fish, clams, nuts and similar constituents.

A special self-emptying device saves additional time and prevents waste. Above all it assures safety, for the operator never needs to reach into the bowl. All parts in contact with food are heavily tinned to prevent corrosion and facilitate cleaning. Many special attachments are available to add to versatility and usefulness. Write for complete details or call your Kitchen Equipment Dealer.

Other BUFFALO Kitchen Equipment...

Bench or pedestal food cutters with 7 pounds to 25 pounds bowl capacity. Bench or pedestal vegetable slicers and slicing attachments for food cutters. Bread slicers—hand or electrically operated. Ice-Cream Slicers and Potato-Chip Slicers.

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DIRECTOR OF NURSING—110-bed; New York: small school with university affiliations: \$4200; maintenance includes pleasant apartment.

DIETITIAN—160-bed; east: September 1st: \$3000, maintenance.

INSTRUCTORS—(a) Clinical. (b) Nursing arts; September 1st: 218-bed; east: starting \$200, maintenance.

SUPERVISORS—(a) Obstetrical; new hospital: starting \$2700, maintenance. (b) Operating room; large hospital; Philadelphia area: \$3000, maintenance. (c) Night: 50-bed; West Coast: \$3000, maintenance; 40-hour week.

RECORD LIBRARIAN—Assistant director medical records department; 700-bed hospital; salary commensurate with training and experience.

LIBRARIAN—Doctors and nurses library: 500-bed hospital: \$200, maintenance.

MEDICAL PERSONNEL EXCHANGE

Continued

TECHNICIANS—(a) X-ray; male; to head Department: \$400. (b) Laboratory; 125-bed; New York City area: \$230, maintenance.

We make no charge for registration.

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(Continued on page 202)

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can save you money and man-hours

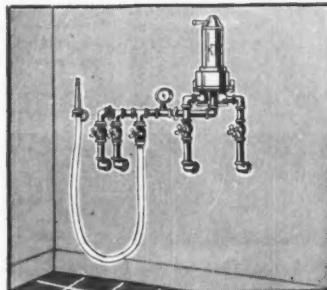
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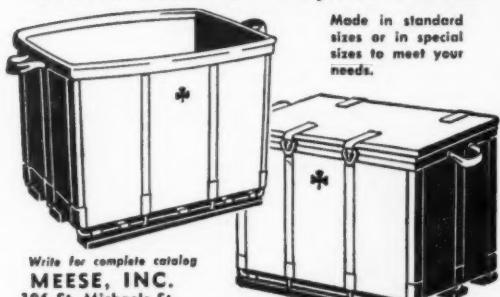
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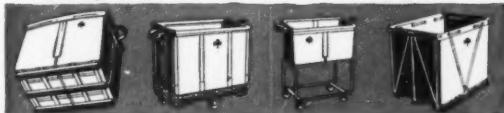
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SHAMROCK
...but they wear...and WEAR!

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A genuine penetrating seal that protects and gives longer life to terrazzo, cement, marble, tile, magnesite. Seals out soil, grease, moisture. Renews and brightens old floors. Safe—Underwriters' Laboratories approved as "Anti-Slip."

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(Continued on page 204)

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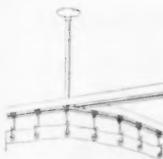
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JERSEY CITY MEDICAL CENTER SCHOOL OF NURSING offers to qualified graduate nurses a four-month course in operating room technique. Full maintenance and stipend granted. Apply to Director of Nurses, Jersey City Medical Center, Jersey City, N. J.

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The RESEARCH and EDUCATIONAL HOSPITALS OF THE UNIVERSITY OF ILLINOIS offer a four months Clinical Course in Orthopedic Nursing to graduate registered nurses. The course provides closely correlated theory and supervised clinical experience in the nursing care of children and adults with orthopedic conditions. Classes enrolled January, May and September. For further information, address Director of Nursing, Research and Educational Hospitals, 1819 West Polk Street, Chicago 12, Illinois.

THE PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of \$60 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

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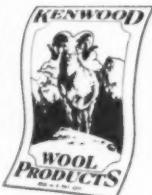
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Vol. 75, No. 1, July 1950

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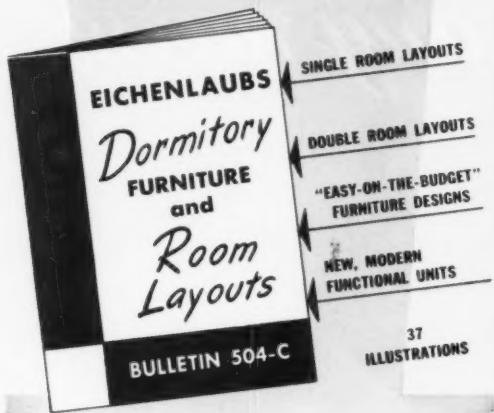
Give! Give your dimes and quarters and dollars. More treatment facilities are needed,

more skilled physicians, more medical equipment and laboratories. The success of great research and educational programs depends on your support.

Your contribution to the American Cancer Society supports these vital efforts. It helps guard your neighbor, yourself, your loved ones. So this year, strike back at cancer . . . Give more than before . . . Give as generously as you can.

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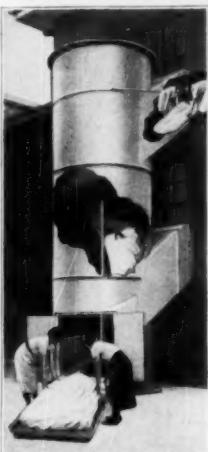
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TRI-PAD^{*}
DISPOSABLE UNDERPADS

What's New for Hospitals

JULY 1950

Edited by BESSIE COVERT

Portable Hot Pack Heater



Designed especially for the heating of small stoves, towels, dressings and smaller Kenny packs, the new Ideal Portable Hot Pack Heater, Model 812-J, is easily carried about. It is compact, weighs less than 11 pounds, and is ready for use wherever desired by simply plugging into any AC light socket. It is finished in stainless steel, completely insulated with Fiberglas so that it can be placed on furniture, floor or wherever convenient without damage to the finish, and can be handled without injury to the operator. The heater can also be used as a sterilizer, providing ample capacity for a large assortment of instruments.

The new heater is thermostatically controlled with a water capacity of 1 quart which lasts approximately five hours, depending on thermostat setting. The anodized aluminum inset for holding the items to be heated or sterilized is readily removed if desired. There are no moving parts and a pilot light indicates when the heater is in operation. Model 812-J, as well as Model 812, permits the operator to control both the heat and the moisture content of the pack. The Swartzbaugh Mfg. Co., Dept. MH, 1336 W. Bancroft St., Toledo 6, Ohio. (Key No. 523)

Electric Cooking Equipment

A new line of heavy duty ranges, bake ovens, fry kettles, griddles and broilers has recently been introduced by Hotpoint as the Glamour line. All units in the line depart from traditional black enamel with their new non-porous silver-gray Permalucent finish which is easy to clean, resists finger marks and grease smears, reduces glare and does not discolor or scorch under long exposure to high heat.

The new ranges and bake ovens are completely automatic, including cooking surface units, thus permitting every type of surface cooking under automatically controlled temperature conditions. Bright signal lights on all units eliminate watching and waiting. Control knobs and switches are finished in red with large white imprinted numerals for greater dialing accuracy. Non-conductive hand guards are part of oven and cabinet handles for extra safety and convenience.

The new range has three top sections, each 1 foot wide, with a thermostat that automatically controls the temperature not only below 500 degrees used for griddling, but also up to 850 degrees for other types of surface cooking, for each section separately. Thus the new range can serve as both an automatic griddle and an automatic hotplate. The heavy duty thermostat is the result of five years of research and development



and controls surface heat from 250 to 850 degrees. All types of surface cooking operations can be performed on the one type of range top.

The oven in the new Superange is equipped with a new type deck that gives uniform heat with fast preheating qualities and affords rapid change-over from high to low temperature work. Red, automatic signal lights indicate when the oven temperature reaches the desired pre-set thermostat reading.

The new bake ovens in the Glamour line have new type, tough, strong Calrod heating units which are said to be 25 per cent more powerful. The elements are armored in non-corroding metal, are sensitive, quickly heated, almost impossible to damage and do not deteriorate. Heating is automatically controlled and the ovens have a temperature range of 200 to 500 degrees.

The new 25 pound capacity auto-

matic electric fry kettle is designed to produce up to 50 per cent more french fried foods and to cut fat consumption up to 60 per cent. The heat is controlled by a thermostat located directly in the cooking fat and the Calrod heating units are immersed in the fat so that all heat is transmitted directly to the cooking compound. The constant heat settings maintained prevent burning and minimize fat loss. A variety of deep fried foods can be cooked in the same fat without interchange of odor or flavor. Hotpoint, Inc., Dept. MH, 227 S. Seeley Ave., Chicago 12. (Key No. 524)

Mother Goose Frieze

An entertaining frieze showing fifteen Mother Goose characters in color is now available in Fabron, the wall covering which is washable and fire safe. Called Mother Goose Frolics, the frieze is bright and colorful and ideally suited to the nursery, pediatric ward and maternity wing of the general hospital and for many other areas in children's hospitals. It is executed on an oyster white base and features robin blue, rose red, brown and flesh colors. Only a few of the characters depicted in this attractive frieze can be shown in the accompanying illustration.

The frieze is 26 inches high with a design repeat of 15 feet. It is available in continuous yardage to any desired length in multiples of one yard. It is designed to be used with Fabron in harmonizing colors, hung horizontally. Like all Fabron it is sunfast, washable and durable and has Underwriters' Laboratories approval for its fire retardant qualities. It is hung like wallpaper and can be easily removed and rehung else-



where if desired. The frieze is known as Mother Goose No. 1601-2. Frederic Blank & Co., Inc., Dept. MH, 230 Park Ave., New York 17. (Key No. 525)

Pacific Mills Contour Sheets



The troublesome under sheet on the patient's bed can now be kept smooth and unwrinkled with the Pacific Mills Contour Sheet. Made to fit the mattress smoothly, these new sheets simplify bed making and give the patient added comfort since they stay tight and cannot creep or wrinkle under him. The sheets are pre-shaped, with four sewn-in mitered corners and generous tuck-under all around. They are woven of Sanforized-labeled type 140 muslin which has extra strength for long wear.

Laundry problems are simplified with Contour sheets since it is unnecessary to iron them. Tumbling is sufficient since the sheets present a smooth, ironed appearance when on the mattress. They are available for the three standard sized hospital mattresses—L-925 for 36 by 6 foot 3 inch mattress; L-926 for 36 by 6 foot 5 inch mattress, and L-927 for 36 by 6 foot 8 inch mattress. **Will Ross, Inc., Distributors, Dept. MH, 4285 N. Port Washington Rd., Milwaukee 12, Wis.** (Key No. 526)

Bottle Cleanser

The Evenflo Brushless Baby Bottle Cleanser is a specially prepared detergent requiring no brushing. It is dissolved in hot water and bottles, nipples and caps are immersed in the solution from 5 to 10 minutes, then rinsed. The cleanser quickly dissolves milk film leaving bottles clean and free from soap film. It saves time and effort, reduces bottle breakage and eliminates the possibility of scratching the glass. The cleanser is packed in 100 pound bags and 1 and 2 pound boxes and is easy on hands. **Pyramid Rubber Co., Dept. MH, Ravenna, Ohio.** (Key No. 527)

Waste Receivers

The new "H" line of Sanette waste receivers has been redesigned to eliminate the risk of exposure and contamination. A single carrying handle prevents hands coming in contact with infectious waste. The cover is opened by stepping on the pedal and the inner waste pail is

easily removed by using the outside handle. When the cover is closed, the entire receptacle may be carried by the same handle. The leakproof, hot-dipped galvanized pail is easy to keep clean and specially processed waxed bag liners are available to keep the pail clean and save frequent washing. The new Model "H" Sanettes are available in 3, 4, 5, 7 and 10 gallon capacities in white enamel, special colors and grained walnut or mahogany. **Master Metal Products, Inc., Dept. MH, 291 Chicago St., Buffalo 4, N. Y.** (Key No. 528)

All-Purpose Light

The new Hospo all-purpose light is designed to serve all lighting functions in the hospital room. It clamps onto the gatch spring of the patient's bed and moves with the backrest as it is raised or lowered. Flexible joints at both ends



of the extension standard permit a 360 degree sweep in any plane.

The light may be turned to the ceiling for indirect room illumination, serves comfortably as a patient's reading light and adequately as an examining light. The unit can be easily detached from the standard and carried to the point of need. A locking device prevents the light from falling off or accidentally coming loose. **Hospo Organization, Dept. MH, 1160 N. Howe St., Chicago 10.** (Key No. 529)

Mop Hanger

Mops, brooms, cleaning brushes and other handled equipment can be hung up with the new holder recently introduced by Geerpres Wringer, Inc. Consisting of two wooden rollers on a strong wire clip mounted in an electroplated metal base plate attached by two wood screws to a wall or inside a closet, the holder is designed for use with practically any thickness of handle. The wooden rollers make it easy to snap handles in and out of the holder while protecting the handles from marring or scratching. **Geerpres Wringer, Inc., Dept. MH, Muskegon, Mich.** (Key No. 530)

Plastic Accessories

The new A.C.M.I. plastic male urinal made of non-irritating plastic Vinylite, electronically seamed, has a latex rubber tapered sleeve for increased comfort. It is light in weight, acid resistant, easily cleaned and comfortable to wear. The waist belt as well as the thigh and leg straps are of cotton elastic and buckles and belts are firmly secured to the urinal by grippers which makes it possible for the belts to adjust automatically to all body contours.

A new line of catheters and tubing is also available made from Polyethylene, an inert synthetic plastic having exceptional electrical insulating properties, inertness to most chemicals and flexibility under a wide variation of temperature range. The plastic is non-irritating to living tissues, light, malleable and easily manipulated. **American Cystoscope Makers, Inc., Dept. MH, 1241 Lafayette Ave., New York 59.** (Key No. 531)

Invalift

Designed to enable a single nurse or attendant to lift, turn, transport or weigh any patient, regardless of size, weight or condition, the Invalift is the result of years of research and development. It employs a unique stretcher frame built of aluminum with supporting stainless steel bands. Two electric motors operate cables which move the patient as desired.

The Invalift has been tested in actual hospital use and has proved effective in saving time and energy in changing bed linen, in bed pan care and for skin treatment. It is said to be especially valuable in the lifting and turning of spinal fusion cases where good alignment is essential. Patients are easily transferred from bed to wheelchair and back with no discomfort and with ease and speed. It provides a weighing scale at the bedside



for non-ambulatory patients. **Invalift, Inc., Dept. MH, 1245 Ranier Ave., Seattle 44, Wash.** (Key No. 532)

Air Conditioners

A new line of unit air conditioners with Rexton "Hammermatic" finish of pale mottled blue gray has recently been announced. The smooth surface can be readily refinished to match special color schemes. Large removable front panels are held in place by spring clips and all interior walls are insulated against sound and heat transfer. The sides are of 16 gauge steel welded to 14 gauge frame members.

The main outlet has adjustable louvers for directing the air stream. Smaller panels at the sides and back are arranged for admitting fresh air or connecting duct work for distributing the treated air. The fan is of the heavy-duty blower type and the $\frac{1}{2}$ h.p. fan motor is rubber mounted. An open space is provided for the insertion of heating coils for winter use. Electric controls are all mounted on a panel behind a small access door. The main dial permits operating the fan alone, the fan and the refrigerating system or shutting off the entire unit. A separate dial adjusts the thermostat. Frick Company, Dept. MH, Waynesboro, Pa. (Key No. 533)

Barium Enema Kit

A new stainless steel container for barium enema administration is now available. Made in one piece, it is easy to clean, both inside and out, and has a rounded, seamless bottom. The barium flow will not clog because the drain at the bottom center consists of a straining acorn outlet well above the sedimentation level. The rubber tubing is heavy-walled to prevent easy kinking.

The container has a capacity of 2 quarts, is supplied with 5 feet of tubing and has a positive flow pinch-off. The can stands firmly on its tripod base or can be hung from the easily mounted

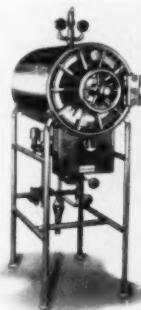


steel wall bracket. Picker X-Ray Corp., Dept. MH, 300 Fourth Ave., New York 10. (Key No. 534)

Automatic Sterilizer Control

The Steritrol is an automatic control for Scanlan-Morris sterilizers recently introduced. With the Steritrol-equipped sterilizer, the operator simply loads the sterilizer, sets the Steritrol dials and is free for other duties. Pointers tell the time remaining for each phase and a buzzer indicates their completion. Panel lights indicate "Sterilize," "Exhaust" and "Finish."

Any size wrapped, unwrapped or liquid loads can be sterilized in the same Steritrol-equipped unit. Both exhaust and sterilizing periods can be pre-set independently for any time from 0 to 60 minutes. The temperature selector can be set for the minimum temperature required throughout the sterilizing period for any type of load. The range varies from minimum "formula" temperature through the proper setting for rubber, fabrics, utensils, solutions and instru-



ments. The exhaust selector can be set to produce a vacuum when sterilization is completed. In case of power failure the sterilizer may be operated manually.

The Steritrol is offered as accessory equipment on all new Scanlan-Morris cylindrical autoclaves, recessed or exposed, for use where electricity is available. Ohio Chemical & Surgical Equipment Co., Dept. MH, Madison, Wis. (Key No. 535)

Improved Bed Lamp

The Campbell Bed Lamp has been redesigned for more flexible use. It can now be completely detached from its base for use in bedside examinations and treatments. The lamp serves efficiently, with only a 40 watt bulb, for general illumination and as a reading light for the patient since the light is concentrated where needed. The lamp clamps to the moving head section of the bed, thus providing proper illumination at any degree of elevation. The lower section has also been redesigned, resulting in sturdier construction. Campbell & Co., Dept. MH, 918 Race St., Cincinnati 2, Ohio. (Key No. 536)

Reese Dermatome



Operating time is saved through use of the Reese Dermatome since suturing is eliminated in most skin graft cases. The Reese Dermatome is designed to excise split skin grafts from .008 inch to .034 inch consistently and accurately and to transplant such grafts to most recipient sites without stretching or contraction of the excised skin.

A special adhesive tape known as Reese Dermatape is mechanically attached to the face of the Dermatome drum and picks up the graft as it is excised. The Dermatape is then detached from the drum, cut to fit the recipient size and anchored in place with dressings alone. The Dermatape loses its adhesion to the graft within five days and may be peeled away at the time of the first dressing without disturbing the newly grafted skin. The Dermatape acts as a splint for the graft and prevents distortion of the cells and tissue spaces during the transplantation process. The Reese 4 Inch Dermatome, No. 1004, comes complete with drum, stand and one set of thickness shims. A sturdy, laminated mahogany carrying case is available if desired. Bard-Parker Co., Inc., Dept. MH, Danbury, Conn. (Key No. 537)

Acoustical Tile

Owens-Corning Fiberglas Corporation has announced the addition of two new natural-beveled acoustical tile to its line of acoustical materials. Known as natural-beveled Fiberglas Textured Acoustical Tile and natural-beveled Fiberglas Perforated Acoustical Tile, the products are incombustible, are easy to clean and maintain, light in weight, dimensionally stable, will not warp or buckle and have high thermal insulating efficiency. The tile can be installed with adhesive, by clipping or adhering to wood furring strips or by a mechanical application to suspended construction. The tile has noise reduction coefficients ranging up to 85 per cent, depending on the method of installing. Owens-Corning Fiberglas Corp., Dept. MH, Toledo 1, Ohio. (Key No. 538)

Odor Eliminator



Air is freshened, odors are removed and bacteria destroyed by use of the new Sanitizaire. Model M-200 is a portable machine, occupying a minimum of space, and operated by simply plugging into an electric outlet and turning the switch. An ultraviolet lamp in the top of the unit destroys odor and bacteria as the air is drawn over it by the air circulator. Thus odor can be removed from a vacant room or an occupied room can be kept odor free and the air fresh. A stronger model, No. 200-D, gives greater deodorization and is designed for use in autopsy rooms, dissecting rooms and other areas with difficult odor problems.

A special unit of the Sanitizaire has been developed for use in disinfecting rooms which have been occupied by infectious cases. When the room is vacated the portable air sterilizer and circulator is brought in, plugged into the light socket and turned on. The manufacturer states that a 30 minute exposure provides greater than a 99 per cent bacterial reduction in average sized rooms. The unit is said to have Underwriters' Laboratories approval and is designed and manufactured by MotionAir, Inc., and distributed by Everest & Jennings, Inc., 761 N. Highland Ave., Los Angeles 38, Calif. (Key No. 539)

Infant Aspirator-Resuscitator

Performing a double duty, the O.E.M. Fletcher Infant Aspirator-Resuscitator provides in the one unit facilities for effective suction and oxygen administration. It was designed by Dr. John P. Fletcher of Toronto for use in the resuscitation of infants and provides controlled suction and oxygen simultaneously by the employment of Bernoulli's principle.

The suction is controlled by the rate of flow of oxygen through the apparatus so that the infant's respiratory tract is protected from damage by excessive suction. A simple safety vent on the oxygen line of the unit protects against excessive pressures of oxygen. The unit is light in weight, small in size, easily

operated, inexpensive and easy to move about, to clean, to service and to store. It is made of chromium plated bronze and features the new O.E.M. wing nut fastening device which simplifies attachment to any standard regulator without use of wrench. **O.E.M. Corporation, Dept. MH, Fitch St., East Norwalk, Conn.** (Key No. 540)

Freeze-Drying Unit

Self-contained and mounted on a flanged floor pedestal, the new Stokes Model 103-FPM Freeze-Drying machine is a completely packaged unit. It consists of a manifold having 24 valve ports, a Freon refrigerated condenser, a high vacuum McLeod gauge and a high vacuum Stokes "Microvac" pump with oil clarifier. It has a batch capacity of 3500 ml. and a capacity of 7500 ml. before defrosting is necessary. **F. J. Stokes Machine Co., Dept. MH, 5900 Tabor Rd., Philadelphia 20, Pa.** (Key No. 541)

Plastic Cup Dispenser

Paper cups can be easily dispensed with the new Lily 957PTH Dispenser.



Made of smooth white molded Polystyrene plastic, the dispenser is fastened to the wall in a horizontal position and holds up to eight Lily #957 paper cups, each having the same capacity as a standard glass tumbler.

The new dispenser is simply cleaned and easily serviced. Screws for mounting on wood and a capsule of carbon tetrachloride to use with Girder Process adhesive pads for tile installation are supplied with the dispenser. It should be especially advantageous in washrooms, utility rooms, locker rooms, bathrooms in private rooms and in similar locations. **Lily-Tulip Cup Corp., Dept. MH, 122 E. 42nd, New York 17.** (Key No. 542)

Traffic-Tred Matting

Traffic-Tred is a new low priced matting designed especially for use as a runner mat. It is $\frac{1}{8}$ inch thick and permits application in any area due to ease in cutting to accurate fit. Three slot constructions are available, closed, open or open on end of slots only and ample aeration and drainage are provided. **American Mat Corp., Dept. MH, 1717 Adams, Toledo 2, Ohio.** (Key No. 543) (Key No. 545)

Aluminum Stock Pot

A new heavy duty aluminum stock pot featuring a faucet for drawing off individual servings has been added to the line of cooking utensils offered by Harlow C. Stahl Company. The new pot has a strainer incorporated for separating solids. It is equipped with strong stainless steel loop handles.

Made of commercial cold-spun aluminum which makes possible close control of bottom, wall and head thickness, the pot is available in 9 sizes from 12 to 36 quart capacity. The extra heavy bottom absorbs heat more quickly and transfers it promptly while preventing scorching and burning of contents. There are no seams or creases to hold waste and the pot is easily cleaned. **Harlow C. Stahl Co., Dept. MH, 1375 E. Jefferson Ave., Detroit 7, Mich.** (Key No. 544)

Royal Electric Typewriter

The new Royal Electric Typewriter is designed to permit a student or secretary to switch from a manually operated to the electric typewriter without a transition period. All controls are located in the same place as on manual typewriters, thus facilitating transition and increasing convenience. The new machine is streamlined, with keyboard positions identical with those of Royal's standard and portable typewriters. Its electrically controlled touch is adjustable to the individual's typing touch and Royal's uniform key lever dip assures development of maximum typing rhythm. The "Magic" Margin permits margins to be set automatically and a control on the left side regulates the speed of the type bar for manifold work.

Finished in the soft gray tone developed by Royal to give added eye comfort to the operator through elimination of glare, the machine has complete powering which enables the operator to tabulate, shift, back space and underscore electrically. The automatic carriage return is electrically controlled by a carriage return key on each side of the keyboard. The machine is completely adaptable for instruction purposes since teaching closely follows that on manually



operated typewriters. **Royal Typewriter Co., Inc., Dept. MH, 2 Park Ave., New York 16.** (Key No. 545)

The MODERN HOSPITAL

Dri-Bed Garments

Beds and clothes of incontinent patients of any age or size can be protected with Dri-Bed garments. The "Pull-on-Panti" is a new addition to this line of garments which can be worn by either bed patients or ambulatory patients to protect bedding and clothing. They are constructed of a plastic material with flannel liners, made with pockets to hold cellulocotton pads to absorb moisture.

The garments are available in various sizes and in styles for varying needs. The "Beddi-Panti" for bed patients is made with zippers for easy application. Elastic webbing around waist and legs ensures fit and comfort. The "Ambi-Panti" for ambulatory patients is also made with a zipper for fastening and a zipper across the front to permit easy changing of pads.

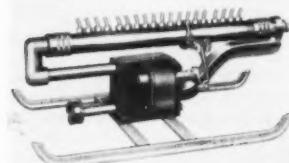
Dri-Bed garments are designed to simplify care of incontinent patients, to minimize odor, to increase patient comfort and to improve morale in the mentally alert incontinent patient. **Dri-Bed Company, Dept. MH, 113 Lyon N.W., Grand Rapids 2, Mich.** (Key No. 546)

Luminous Fluorescent

The new Guthglow luminous fluorescent is available for standard 40 watt lamps and also for 4 and 8 foot Slimline Single-Pin lamps. The unit is equipped with polystyrene plastic or Albalite glass side panels which direct a portion of the light upward and outward. Low brightness Alzak aluminum baffles shield the lamp from direct view from below. **The Edwin F. Guth Co., Dept. MH, 2615 Washington Ave., St. Louis 3, Mo.** (Key No. 547)

Improved Sprinkler

The versatile "Shower Queen" Sprinkler, which covers a rectangular area up to 3250 square feet, has been redesigned for more efficient operation. The area to be covered is regulated at the faucet by the volume of water used. The "Shower Queen" throws the water high into the air from where it falls gently, wetting



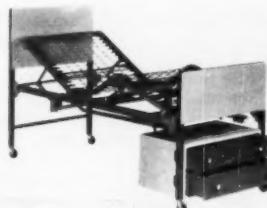
the entire area evenly. It is easily adjustable to operate right up to buildings without wetting walls, walks or windows. It is not necessary to shut off the

water in relocating the sprinkler as it can be pulled by the hose.

Among the improvements in the new model are needle point bearing changes in the hydraulic motor to increase its power at low water pressures, new combination journal and thrust bearing, adjustable screw to permit compensation for wear after long and constant use, easily accessible packing gland and runners of a new, more durable alloy metal. The capacity can be controlled for any need up to 300 gallons per hour. **Acme Sprinklers, Dept. MH, 412 Walbridge St., Kalamazoo 3, Mich.** (Key No. 548)

Chest-Bed

Drawer space for the patient's personal belongings or for linens or nursing supplies is immediately available with the new Inland Chest-Bed. The heavy-duty posture bed No. CB-370 has two full-sized drawers attached as a unit at the foot. They slide easily on drawer guides and open out from the end of the bed. The telescoping handles for operating the spring do not mar the bed ends or the chest, and the drawers do not interfere with operation of the spring.



The built-in chest is firmly joined to the foot of the bed by four corner locks. It is completely sealed on sides, back, top and bottom, thus protecting the contents of the drawers. The two drawers are 31 by 17 inches each, 5½ inches high. Bed ends are of modern paneled design and the bed has ball bearing rubber wheel casters, heavy-duty spring clip sockets, mattress guard and double wedge corner locks. **Inland Bed Co., Dept. MH, 3921 S. Michigan, Chicago 15.** (Key No. 549)

Deeminizer

The Deeminizer is a self-contained portable instrument for producing mineral-free water, equivalent in ionic purity to triple-distilled, at a low cost. The unit has no valves and can be placed in any location and operated immediately without preparation. It produces approximately 5 gallons per hour. The Deeminizer employs Deeminite which is described as a new development in ion-exchange resins. **Crystal Research Laboratories, Inc., Dept. MH, 29 Allyn St., Hartford, Conn.** (Key No. 550)

Tablet Arm Attachment



Nursing schools and other classroom areas, offices and lecture rooms will find the new tablet arm for attachment to chairs for note taking, lectures and meetings convenient and economical. The tablet arm folds down when not in use, thus giving a versatility to the chairs not otherwise possible.

The tablet arm is available in blue or standard colors or in Formaloid construction. Aluminum banding is used for extra strength as well as attractive appearance. **Royal Metal Mfg. Co., Dept. MH, 185 N. Michigan Ave., Chicago 1.** (Key No. 551)

Vertical Boiler Unit

A new line of low cost vertical, tubular, high pressure, boiler-burner units has recently been announced, sized from 3 to 15 h.p. The units are equipped with a standard York-Heat gun type burner, automatic controls, low water cut-off, condensate return system and draft adjuster. They have been especially designed to provide low cost, high pressure steam to all plants requiring quick automatic steam. Boilers are full length riveted, vertical, tubular construction, furnished complete with base, combustion chamber and trim. **York-Shipley, Dept. MH, 71 Jessop Place, York, Pa.** (Key No. 552)

Paraffin Tissue Section Bath

A new water bath to speed histological processing was developed to avoid common inconveniences and difficulties experienced with improvised equipment. The new Tissue Section Bath provides heat and light from one light bulb source which is covered by a black center plate under the Pyrex glass dish containing water and tissue sections. Light is allowed to diffuse at the edges of the dish and is refracted to give the ideal light for outlining the slices. A slot at the side of the bath base provides illumination of slides or notebook on the laboratory table. **Precision Scientific Co., Dept. MH, 3737 N. Cortland St., Chicago 47.** (Key No. 553)

Bactine

Bactine is a chemical solution with specific properties producing a safe and powerful bactericide, fungicide and deodorant, and an efficient detergent. It is a clear, colorless liquid with a clean fresh odor. It is gentle to the skin and almost painless, even on abrasions or open wounds. It is effective for the relief of itching of the skin due to insect bites, sunburn and other skin irritations and it is effective against most pathogenic bacteria and against common pathogenic fungi.

Bactine is used to render skin, clothing, glass, metal, plastic and enamel surfaces surgically clean, it does not stain, and it leaves a residue on disinfected surfaces which is said to make them antibacterial for a prolonged period. It is gentle and does not dry or otherwise injure the skin but possesses mildly cooling and anesthetic qualities. Bactine eliminates odors and destroys bacteria responsible for putrefaction. It is surface-active, enhancing its cleansing and penetrating actions. It is supplied in 6 fluid ounce bottles. **Miles Laboratories, Inc., Dept. MH, Elkhart, Ind.** (Key No. 554)

Tilting Pail-Rack

Designed to give both ease and speed in filling soda lime canisters from 35 pound pails, the new Mallinckrodt tilting Pail-Rack is made of all steel. It can be easily assembled in a minimum of time and is of sturdy, yet simple, construction. The convenient Pail-Rack is provided without cost to quantity purchasers of Mallinckrodt Soda Lime. **Mallinckrodt Chemical Works, Dept. MH, 2nd and Mallinckrodt Sts., St. Louis 7, Mo.** (Key No. 555)

Institution Sized Jell-O

A new institution sized package is now available in Jell-O pudding in chocolate, vanilla and butterscotch flavors, each using one gallon of milk. The chocolate and butterscotch flavors are in the 2 pound size and the vanilla is in the 1½ pound size. The new packaging supplements the regular 5 pound institution size. **General Foods Corp., Dept. MH, 250 Park, New York 17.** (Key No. 556)

Floor Drain

A special lock, which allows only authorized personnel to have access to the internal strainer and drainage line, is used on the new Vandal Proof Floor Drain recently announced. A special tamperproof cover is also a part of the drain and is designed to eliminate the possibility of deliberate clogging or damaging of the drain. **J. A. Zurn Mfg. Co., Dept. MH, Erie, Pa.** (Key No. 557)

Pharmaceuticals

Sugracillin Flavored Granules

Sugracillin supplies flavored granules of buffered crystalline penicillin G potassium and is designed for use in pediatrics and for patients who prefer fluid medication. It has the same action as other oral penicillin products and can be stored at room temperature before dissolving. It is supplied in a 60 cc. size bottle, containing 1,200,000 units penicillin. The contents of the bottle are dissolved in enough water to make 60 cc. of solution. This gives a concentration of 20,000 units of crystalline penicillin G per cc., approximately 100,000 units per teaspoonful. **The Upjohn Co., Dept. MH, P.O. Box 271, Kalamazoo 99, Mich.** (Key No. 558)

Lactum and Dalactum

Two new products are being introduced for infant formulas. Lactum is a whole cow's milk and Dextri-Maltose formula containing added vitamin D. It is homogenized, evaporated and sterilized and is used by merely mixing with an equal volume of water. Dalactum is a formula made from low fat cow's milk and Dextri-Maltose with added vitamin D, homogenized, evaporated and sterilized. It is designed to meet the need for a low fat formula and is mixed as easily as Lactum, by combining with boiled water. Both products are supplied in cans containing 13 fluid ounces, equivalent to 14½ ounces net weight. **Mead Johnson & Co., Dept. MH, Evansville 21, Ind.** (Key No. 559)

Cellothyl Granules

Cellothyl, the methylcellulose bulk laxative, is now available in granule form. The new product has been introduced especially for pediatric patients although it will also be used for adults. The Cellothyl granules are identical in composition to the tablets. Both are nontoxic, non-antigenic and non-reactive in the gastrointestinal tract. Cellothyl granules are supplied in bottles of 25 and 100 grams. **Chilcott Laboratories, Division of The Maltine Co., Dept. MH, Morris Plains, N.J.** (Key No. 560)

Elixir Syndrox Hydrochloride

Elixir Syndrox Hydrochloride, indicated in mild depressions, obesity, narcolepsy, and as an adjunct in the treatment of acute and chronic alcoholism, is a new dosage form of Syndrox Hydrochloride. It is a palatable, amber-colored elixir containing 20 mg. Methamphetamine hydrochloride "McNeil" per fluid ounce. It is supplied in pint and gallon sizes. **McNeil Laboratories, Inc., Dept. MH, Philadelphia 32, Pa.** (Key No. 561)

Bacitracin Oral Tablets

Bacitracin Oral Tablets are described as a successful means of treating intestinal amebiasis. Administration of this relatively new antibiotic is said to bring symptoms rapidly under control. Since Bacitracin is not appreciably absorbed from the intestinal tract, high concentrations are built up in the intestinal contents to act directly on the ameba or other intestinal organisms. Each Bacitracin Oral Tablet contains 10,000 units. **C.S.C. Pharmaceuticals, Div. of Commercial Solvents Corp., Dept. MH, 17 E. 42nd St., New York 17.** (Key No. 562)

Sedamyl

Sedamyl is designed for use as a sedative without hypnosis during periods of emotional and nervous tension so that the patient retains full control of his mental and physical faculties. It is said to be unattended by unpleasant after effects. Sedamyl Tablets are supplied in tubes of 20 and bottles of 100. **Schenley Laboratories, Inc., Dept. MH, 350 Fifth Ave., New York 1.** (Key No. 563)

Perazil

Perazil is a new type antihistaminic designed for prolonged action so that one dose is effective for 12 to 24 hours. It produces relatively low incidence of side effects and is active at low dosage. The drug is a piperazine and is indicated for treatment of allergic conditions for which histamine antagonists are effective. Perazil brand chlorcyclizine hydrochloride, 50 mg. compressed, scored tablets are supplied in bottles of 100 and 500. **Burroughs Wellcome & Co. (U.S.A.) Inc., Dept. MH, Tuckahoe 7, N.Y.** (Key No. 564)

Amrulal Tablets

Amrulal Tablets are designed for therapy as cardiac stimulation, mild sedation, diuresis and prophylaxis of capillary fragility in hypertension. Composed of aminophyllin, rutin and phenobarbital, the tablets are supplied in bottles of 100 and 1000. **Bio-Ramo Drug Co., Inc., Dept. MH, Baltimore 1, Md.** (Key No. 565)

Rabies Vaccine

A new rabies vaccine for dog immunization has been announced after being tested successfully on more than 12,000 dogs. It will be available to aid in the prevention of rabies in dogs. The new vaccine is produced from live virus which has been modified by growth in chick embryos. **Lederle Laboratories Div., American Cyanamid Co., Dept. MH, Pearl River, N.Y.** (Key No. 566)

Product Literature

- A new publication, called "O R S," is being made available by Davis & Geck, Inc., 57 Willoughby St., Brooklyn 1, N.Y. Volume 1, Number 1, is the June 1950 issue. The publication is designed to "provide the operating room nurse with a medium for keeping in touch with the activities in the field, exchanging ideas, bringing new methods to light and discussing topics of general interest." The first issue contains 16 pages and cover and is attractively laid out and printed with a great many illustrations. In addition to technical information and news, three pages of fashion previews add a personal touch. (Key No. 567)
- The "Deknatel Surgical Silk Manual" just published by J. A. Deknatel & Son Inc., 96-20 222nd St., Queens Village 8, Long Island, N.Y., presents helpful information through the question and answer method. Twenty practical questions regarding Deknatel Surgical Silk are asked and fully answered. The 16 page booklet provides two blank pages for notes. (Key No. 568)
- Full details on the new improved American DeLuxe Floor Maintenance Machine manufactured by the American Floor Surfacing Machine Co., 546 S. St. Clair St., Toledo 3, Ohio, are given in a new 4 page folder recently received. The new features of the machine, which is designed for dry or wet cleaning and maintenance operations on a variety of floors, are discussed. (Key No. 569)
- Printed in full color to illustrate the advantages of color conditioning for hospitals, schools, offices, auditoriums, cafeterias and many other areas, the new 32 page "Du Pont Color Conditioning" booklet presents down to earth ways of making color work for you. Color Conditioning is a scientific painting plan resulting from many years of research in the functional use of color. Color as a means of providing a cheerful atmosphere, emotional relaxation, visual comfort and other reactions is discussed in its relation to the use to be made of it. The booklet is available from Department P.R. 2, Finishes Div., Du Pont Co., Wilmington, Del. (Key No. 570)
- A variety of practical suggestions on efficient institutional dishwashing is incorporated in a new illustrated bulletin, "Better Ways to Cleaner Wares," offered by Calgon, Inc., Hagan Bldg., Pittsburgh 30, Pa. Actual photographs illustrate the 16 page booklet which discusses the use of "Calgonite" mechanical dishwashing compound, the Calgonite Mechanical Dispenser, the Calgonite Electronic Control which automatically maintains washing solution at effective strength without waste and special compounds. (Key No. 571)
- The new line of library furniture and equipment available from the Library Bureau of Remington Rand Inc., 315 Fourth Ave., New York 10, is described and illustrated in detail in Catalog LB 403 1-50 recently published. Containing illustrations and data on modern wood furniture of the "Trend" design as well as custom-made charging desks, wood and steel shelving, exhibit cases, magazine racks, fire-resistant cabinets and other library products and services, the 52 page booklet also shows in pictures the manufacturing operations that go into the creation of "Trend" furniture. Pictures of 14 installations of Library Bureau equipment in leading libraries are shown. The book is fully indexed and contains a list of Library Bureau installations. (Key No. 572)
- "Klenzade Sanitation Specialists Catalog" is the title of a loose-leaf booklet, cross indexed by product names, product groups and cleaning jobs, giving full information on the line of detergents, bactericides and other products offered by Klenzade Products, Inc., Beloit, Wis. In addition to product data, the booklet carries a technical description of each product for those interested in the technical aspects. (Key No. 573)
- "Upholstering with Latex Foam—America's No. 1 Cushioning Material" is the title of a new booklet issued by the Natural Rubber Bureau, 1631 K St. N. W., Washington 6, D. C. The booklet is fully illustrated and gives complete details on the features of latex foam, its varied uses in upholstery work, the forms in which it is available, methods of application and a list of manufacturers. (Key No. 574)
- The story of Infra Insulation, for installation in ceilings, walls and floors to resist heat and vapor flow, is told in the third revised edition of "Simplified Physics of Thermal Insulation," a booklet issued by Infra Insulation, Inc., 10 Murray, New York 7. (Key No. 575)
- Detailed instructions for sharpening 26 leading makes of power lawn mowers are given in a 36 page booklet, "How to Sharpen Power Mowers," published by Foley Mfg. Co., Dept. L-36, Minneapolis 18, Minn. Full descriptive data are supplemented by illustrations of each mower discussed. (Key No. 576)
- The problems of resurfacing service floors of various types are dealt with in a special bulletin, "Service Floors for Industries and Institutions," recently issued by United Laboratories, Inc., 16801 Euclid Avenue, Cleveland 12, Ohio. Four general types of materials for renewing old floors are described and the conditions under which each type of material should be considered are discussed. (Key No. 577)
- Detailed information on Meyer Steel-forms, used in reinforced concrete construction, is given in Bulletin No. 4001C recently released by Ceco Steel Products Corp., 5601 W. 26th St., Chicago 50. Specifications and diagrammatic drawings supplement the descriptive information and illustrations of the product. (Key No. 578)
- Basic data on pollens and spores are presented in a booklet, "The What, When, Where of Hay Fever," prepared by the Botanical Research Dept. of Abbott Laboratories, North Chicago, Ill., under the direction of Oren C. Durham, chief botanist. The booklet is designed to assist in the diagnosis and treatment of hay fever. Charts, maps and tables show the seasons for tree, grass, ragweed, Russian thistle and other pollens in every state and the pollen incidence in grains per cubic yard of air for leading cities during pollen periods. (Key No. 579)
- A practical and easily understood one-lesson course on asphalt tile installation is offered in a pamphlet, "It's So Easy to Install Your Own Beautiful Kentile Floor," recently published by David E. Kennedy, Inc., 58 Second Ave., Brooklyn 15, N. Y. Each step in the process is explained with information on materials needed, how to measure a room, how to plan the border, how to spread the adhesive, laying of the tile and how to cut the boarder. (Key No. 580)
- Plans for a combination paper towel dispenser and waste receptacle recessed into the wall to save space in public and personnel washrooms have been developed by Scott Paper Company, Chester, Pa., and are available from the Washroom Advisory Service of that company. The plans include a towel cabinet recessed flush with the wall with the towels dispensed at shoulder level and a waste receptacle, also recessed, at waist-level. The unit is 14 inches wide, 6 feet 2 inches high and 7½ inches deep. (Key No. 581)
- How to select the proper type of electric water cooler for normal and abnormal atmospheric conditions is discussed in Form 20, a condensed catalog folder published by Cordley & Hayes, 443 Fourth Ave., New York 16. Also included are details on how to select the proper size cooler for a given requirement, together with information on 12 models of Cordley electric water coolers. (Key No. 582)
- Detailed information on all Tracerlab products designed for every application of radioisotopes is given in Catalog B issued by Tracerlab Inc., 130 High St., Boston 10, Mass. Included is descriptive material on instruments, Geiger Mueller tubes, laboratory instruments and other equipment. (Key No. 583)

• "How to Have a Beautiful Lawn" is the title of a booklet made available by The Eclipse Lawn Mower Co., Prophets-town, Ill. The 16 page pamphlet gives detailed information on the essentials for a good lawn, laying out the lawn, seed, grading, preparation of soil, sowing, care after sowing, feeding and fertilizing, watering, weeds, pests and lawn mowing with data on Eclipse lawn mowers. (Key No. 584)

• "LOF Glass for Construction" is discussed in a 28 page booklet issued by Libbey-Owens-Ford Glass Co., Toledo 3.

Ohio. All types of construction glass manufactured by the company are described with technical data on qualities, uses, specifications, processing, durability and other pertinent details. Illustrations of the various products as well as of installations add to the interest of this reference booklet. (Key No. 585)

• The complete line of "Packaged Air Conditioners" developed by the company is covered in a new 12 page two color Catalog PM 79-0100 issued by the General Electric Co., Air Conditioning Dept., Bloomfield, N.J. Units in 2, 3, 5,

7½ and 10 h.p., capacities are described with illustrations of the conditioners and a cutaway drawing showing how a packaged unit operates. (Key No. 586)

Book Announcements

Lea & Febiger, Washington Square, Philadelphia 6, Pa. Kessler, in collaboration with 20 other authors, "The Principles and Practices of Rehabilitation," 448 pp., \$9. Pohle, "Clinical Radiation Therapy," 2nd ed., 902 pp., \$15. Thorndike, "A Manual of Bandaging, Strapping and Splinting," 2nd ed., 148 pp., \$2. Wesson, "Urologic Roentgenology," 3rd ed., 282 pp., \$7.50. (Key No. 587)

W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. Goodnow, "Nursing History in Brief," 3rd ed., 274 pp., \$3. Harrow, "Textbook of Biochemistry," 5th ed., 609 pp., \$6. Heisig, "The Theory and Practice of Semimicro Qualitative Analysis," 2nd ed., 356 pp., \$3.50. Villee, "Biology: The Human Approach," 580 pp., \$5. The Staff of the Vincent Memorial Laboratory of the Vincent Memorial Hospital, affiliated with Massachusetts General Hospital, "The Cytologic Diagnosis of Cancer," 229 pp., \$6.50. Wilder, "A Primer for Diabetic Patients," 9th ed., 200 pp., \$2.25. Williams, "Textbook of Endocrinology," 793 pp., \$10. Williams and Wetherill, "Personal and Community Hygiene Applied," 610 pp., \$4. Williams, "Personal Hygiene Applied," 9th ed., 471 pp., \$3.25 (Key No. 588)

Suppliers' News

The American Laundry Machinery Co., Cincinnati 12, Ohio, announces the election of James M. Garvey as President of the company. Mr. Garvey succeeds Harvey H. Miller who died on May 19 after more than a year of impaired health.

Herschel H. Leiter, well known in the hospital, orthopedic and surgical fields for his work in the development of orthopedic and fracture appliances as president of DePuy Manufacturing Co., Warsaw, Ind., died on May 8 at Nashville, Tenn.

The National Radiator Co., Johnstown, Pa., manufacturer of boilers, radiators and heating accessories, announces the establishment of a branch sales office at 5736 Twelfth St., Detroit 8, Mich. The new office will be under the direction of Victor W. Blackney, branch manager.

John Sexton & Co., 500 N. Orleans St., Chicago 90, wholesale grocer, announces the opening on August 1 of a new branch at 1950 Army St., San Francisco, Calif., to serve the Pacific Coast territory west of the Rockies.

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it. If you read the hospital copy or the administrator's copy of The MODERN HOSPITAL or for any other reason do not wish to clip the magazine itself, upon request we shall be glad to send you regularly a reprint of this department containing the coupon.

Bessie Covert
Editor, "What's New for Hospitals"

<input type="checkbox"/> 523 Portable Hot Pack Heater	<input type="checkbox"/> 557 Floor Drain
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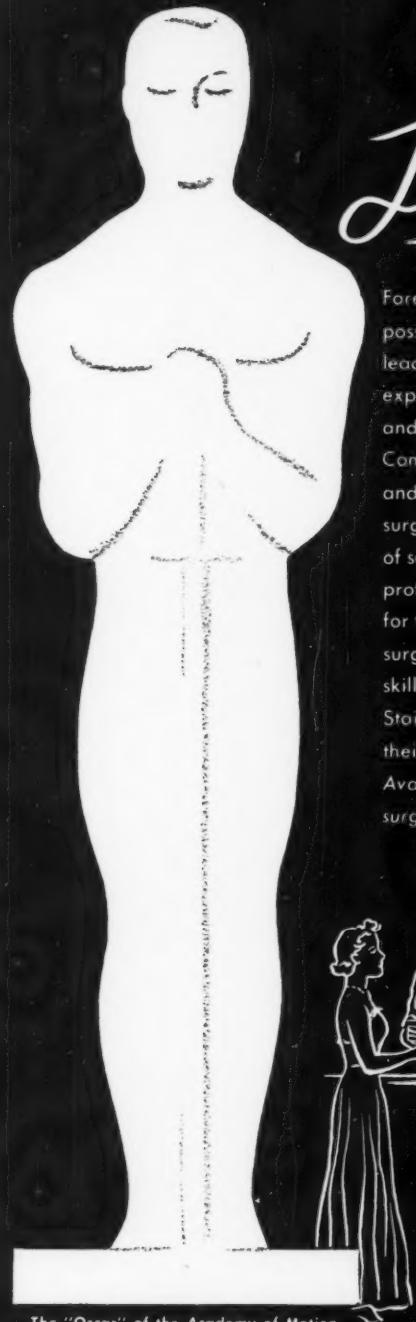
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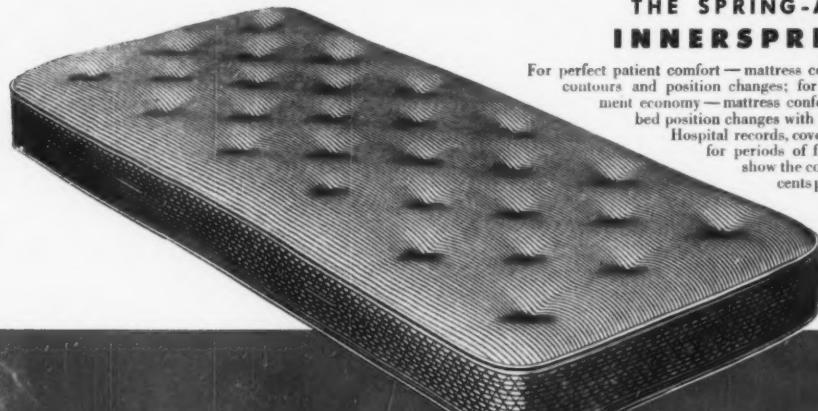
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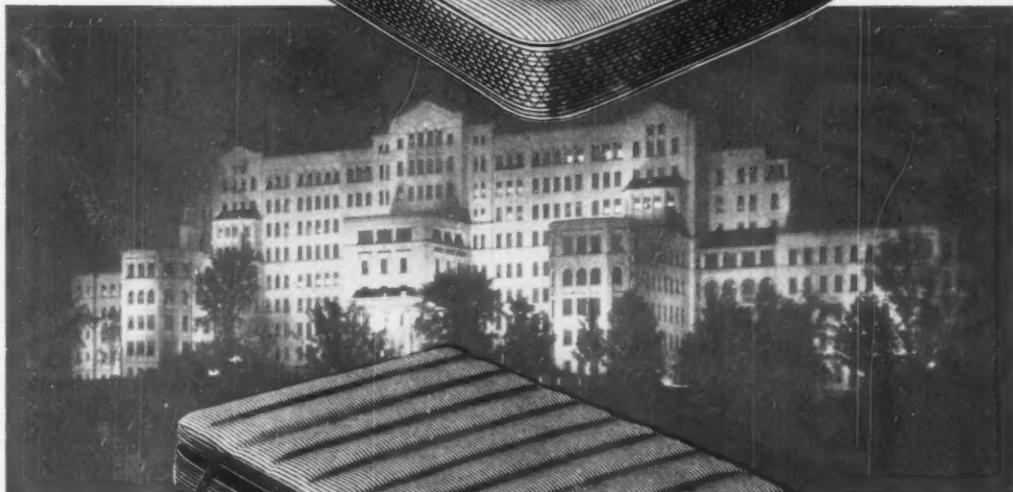
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